that produces the value of the five (5) year Constant Maturity Treasury Rate to be used at each redetermination date.

(6) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subsection (5)(b) of this section up to an additional one hundred (100) basis points to reflect the value of the equity index benefit. The present value at the contract issue date and at each redetermination date thereafter of the additional reduction shall not exceed the market value of the benefit. The ***commissioner***~~[executive director]~~ may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such demonstration that is acceptable to the ***commissioner***~~[executive director]~~, the ***commissioner***~~[executive director]~~ may disallow or limit the additional reduction.

(7) The ***commissioner***~~[executive director]~~ may promulgate administrative regulations in accordance with KRS Chapter 13A implementing the provisions of subsection (6) of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts for which the ***commissioner***~~[executive director]~~ determines adjustments are justified.

(8) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. This present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(9) For contracts which provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid

prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, the present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the insurer on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the insurer to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under the contracts shall be at least equal to the cash surrender benefit.

(10) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, the present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, and increased by any existing additional amounts credited by the insurer to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(11) For the purpose of determining the benefits calculated under subsections (9) and (10) of this section, in the case of annuity contracts under which an election may be

made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(12) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(13) Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(14) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of subsections (8), (9), (10), (11), and (13) of this section, additional benefits payable:

(a) In the event of total and permanent disability;

(b) As reversionary annuity or deferred reversionary annuity benefits; or

(c) As other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits;

shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up

annuity, cash surrender and death benefits that may be required by this section. The inclusion of these additional benefits shall not be required in any paid-up benefits, unless these additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

(15) (a) After August 1, 2005, any insurer may file with the ***commissioner*** ~~[executive director]~~ a written notice of its election to apply the provisions of this section on a contract-form by contract-form basis to annuity contracts issued by the insurer during the period from the date of the election through June 30, 2006.

(b) Insurers shall apply the provisions of this section to annuity contracts issued on or after July 1, 2006.

➔Section 1188. KRS 304.15-390 is amended to read as follows:

(1) A domestic life insurer may establish one (1) or more separate accounts, and may allocate thereto, in accordance with the terms of a written contract or agreement, any amounts paid to the insurer in connection with a pension, retirement or profit-sharing plan, life insurance, or an annuity which are to be applied to provide benefits payable in fixed or in variable dollar amounts or in both.

(2) The income, if any, and gains and losses, realized or unrealized, on each such account shall be credited to or charged against the amounts allocated to the account in accordance with the agreement, without regard to other income, gains or losses of the insurer.

(3) Assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then in accordance with the terms of the applicable contract or agreement; except, that the portion of the assets of such separate account at least equal to the insurer's reserve liability with regard to the guaranteed benefits and funds referred to in subsection (1) of this section, if any, shall be valued in accordance with rules otherwise applicable to the insurer's assets.

(4) If the agreement provides for payment of benefits in variable amounts, the contract shall contain a statement of the essential features of the procedure to be followed by the insurer in determining the dollar amount of such variable benefits. Any such contract and any certificate issued thereunder shall state that such dollar amount may decrease or increase and shall contain on its first page a statement that the benefits thereunder are on a variable basis.

(5) No domestic life insurer, and no other authorized life insurer, shall be authorized to deliver within this state any such contract or agreement providing benefits in variable amounts until the insurer has satisfied the ***commissioner***~~[executive director]~~ that its condition or methods of operation in connection with the issuance of such contracts or agreements will not render its operation hazardous to the public or its policyholders in this state. In determining the qualification of an insurer requesting such authority, the ***commissioner***~~[executive director]~~ shall consider, among other things:

(a) The history and financial condition of the insurer;

(b) The character, responsibility and general fitness of the officers and directors of the insurer; and

(c) In the case of an insurer other than a domestic insurer, whether the statutes or regulations of the jurisdiction of its incorporation provide a degree of protection to policyholders and the public which is substantially equal to that provided by this section and the rules and regulations issued thereunder.

(6) Amounts allocated by domestic life insurers to separate accounts in the exercise of the power granted by this section shall be owned by the insurer and the insurer shall not be, or hold itself to be, a trustee, in respect to such amounts.

(7) The ***commissioner***~~[executive director]~~ shall have sole authority to regulate the issuance and sale of such agreements, and to make rules and regulations for the effectuation of this section.

➔Section 1189. KRS 304.15-410 is amended to read as follows:

In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in KRS 304.6-150, 304.6-155 and 304.6-180, the reserves which are held under any such plan must:

(1) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(2) Be computed by a method which is consistent with the principles of this standard valuation law;

as determined by regulations promulgated by the ***commissioner***~~[executive director]~~.

➔Section 1190. KRS 304.15-700 is amended to read as follows:

(1) No person may act as a life settlement provider without first having obtained a license as a life settlement provider from the ***commissioner***~~[executive director]~~.

(2) Except as provided in paragraph (b) or (c) of this subsection, no person may broker, solicit, or negotiate life settlement contracts between an owner and one (1) or more life settlement providers or otherwise act on behalf of an owner without first having obtained a license as a life settlement broker from the ***commissioner***~~[executive director]~~ as follows:

(a) All applicants for a life settlement broker license shall attend the required life broker training and pass a life broker examination designated by the ***commissioner***~~[executive director]~~ through administrative regulation.

(b) A person licensed as a resident or nonresident insurance agent with a life line of authority, as set forth in KRS 304.9-030(2)(a), shall be deemed to meet the licensing requirements of a life settlement broker and shall be permitted to operate as a life settlement broker without obtaining a license as a life

settlement broker as set forth in this subtitle if:

1. That person has been licensed as a resident insurance agent with a life line of authority in his home state for at least one (1) year;
2. Not later than thirty (30) days from the first day of operating as a life settlement broker, the agent notifies the ***commissioner***~~[executive director]~~, on a notification form prescribed by the ***commissioner***~~[executive director]~~, that he is acting as a life settlement broker and pays any applicable fees to be determined by the ***commissioner***~~[executive director]~~. The notification shall include an acknowledgment by the agent that he will operate as a life settlement broker in accordance with this subtitle; and
3. Irrespective of the manner in which a life settlement broker or life insurance agent is compensated, the life settlement broker or life insurance agent is deemed to represent only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions and in the best interests of the owner.

(c) Notwithstanding this subsection, a person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the owner, whose compensation is not paid directly or indirectly by the life settlement provider, may negotiate life settlement contracts without having to obtain a license as a life settlement broker.

(d) A life insurance agent operating as a life settlement broker in accordance with paragraph (b) of this subsection, prior to the execution of the life settlement contract by all the parties for which such agent is operating as a life settlement broker, shall have in force and file with the ***commissioner***~~[executive director]~~ evidence of financial responsibility as follows:

1. A policy of insurance covering the legal liability of the agent as the result of erroneous acts or failure to act in his or her capacity as a life settlement broker, and inuring to the benefit of any aggrieved party as the result of any single occurrence in the sum of not less than twenty thousand dollars ($20,000) and one hundred thousand dollars ($100,000) in the aggregate for all occurrences within one (1) year; or

2. An agreement with a licensed life settlement provider whereby the agent is an additional insured on the policy of insurance covering the legal liability of both the life settlement provider and the agent as the result of erroneous acts or failure to act in his or her capacity as a life settlement broker on a life settlement contract to which the life settlement provider is a party, in the sum of twenty thousand dollars ($20,000) for any single occurrence; or

3. A deposit with the ***commissioner***~~[executive director]~~ of cash or a cash surety bond, executed by an insurer authorized to write business in this Commonwealth, in the sum of twenty thousand dollars ($20,000), which shall be subject to lawful levy of execution by any party to whom the agent has been found to be legally liable as the result of erroneous acts or failure to act in his or her capacity as a life settlement broker.

(3) Application for a life settlement provider license or a life settlement broker license shall be made in accordance with KRS 304.9-150.

(4) Licenses for life settlement providers and life settlement brokers shall be in accordance with Subtitle 9 of KRS Chapter 304. A business entity licensed as a life settlement broker or life settlement provider shall designate individuals to act under its license in accordance with KRS 304.9-133.

(5) Prior to issuance of a license as a life settlement broker or life settlement provider, except as provided in subsection (2)(d) of this section, the applicant shall file with

the ***commissioner***~~[executive director]~~, and thereafter for as long as the license remains in effect shall keep in force, evidence of financial responsibility in the sum of not less than twenty thousand dollars ($20,000) per occurrence, and the sum of one hundred thousand dollars ($100,000) in the aggregate, for all occurrences within one (1) year. This evidence shall be in the form of an errors and omissions insurance policy issued by an authorized insurer, a bond issued by an authorized corporate surety, a deposit, or any combination of these evidences of financial responsibility. The policy, bond, deposit, or combination thereof shall not be terminated without thirty (30) days' prior written notice to the licensee and the ***commissioner***~~[executive director]~~. This subsection shall not apply to a life insurance agent operating as a life settlement broker in accordance with subsection (2) of this section.

(6) No person shall use a life settlement contract form or provide to an owner a disclosure statement form in this Commonwealth unless it has been filed with and approved by the ***commissioner***~~[executive director]~~ in the following manner:

(a) At the expiration of sixty (60) days from the date the filing is complete, the form filed shall be deemed approved unless the ***commissioner***~~[executive director]~~ has by order given prior approval or disapproval. Approval of a form by the ***commissioner***~~[executive director]~~ shall constitute a waiver of any unexpired portion of the waiting period. The ***commissioner***~~[executive director]~~ may extend by not more than thirty (30) days the time period in which he or she may approve or disapprove the form. The ***commissioner***~~[executive director]~~ shall give notice to the licensee of the extension before expiration of the initial sixty (60) day period. At the expiration of the extended period, and in the absence of the prior approval or disapproval, the form shall be deemed approved. The ***commissioner***~~[executive director]~~ may at any time, after notice and for cause shown, withdraw any

approval. The ***commissioner***~~[executive director]~~ shall disapprove a life settlement contract form or disclosure statement form if, in the determination of the ***commissioner***~~[executive director]~~, the contract or provisions contained therein are unreasonable, contrary to the interests of the public, or otherwise are misleading or unfair to the owner. Upon notice and hearing the ***commissioner***~~[executive director]~~ shall withdraw approval of any contract later determined to be unreasonable, misleading, unfair, or contrary to the interest of the public; and

(b) Forms may be submitted simultaneously with an application or at any time during the process of approving an application for a license pursuant to this subtitle or at any other time.

(7) A licensed life settlement provider shall not use any person to perform the functions of a life settlement broker as defined in KRS 304.15-020 unless the person holds a current and valid license or is a licensed insurance agent authorized pursuant to this subtitle to operate as a life settlement broker. A licensed life settlement broker shall not use any person to perform the functions of a life settlement provider as defined in KRS 304.15-020 unless the person holds a current and valid license as a life settlement provider.

(8) If any employee of a licensee violates any provision of KRS 304.15-020, 304.15-700 to 304.15-720, 304.42-190, and 304.99-126, the ***department***~~[office]~~ may take disciplinary action against the employer licensee.

(9) When a life settlement provider elects to use a related provider trust, the life settlement provider shall file notice of its intention to use that trust with the ***department***~~[office]~~ with a copy of the trust agreement. Any change in the trust agreement shall be filed with the ***commissioner***~~[executive director]~~ prior to its effect.

(10) Any additional death benefit payment on a life insurance policy that is the subject of

a life settlement contract with a double or additional indemnity for accidental death shall be payable to the following:

(a) The beneficiary last named by the policy owner prior to entering into the life settlement contract; or

(b) To the estate of the owner in the absence of a beneficiary.

(11) An insurer that issued a policy that is the subject of a life settlement contract shall not be responsible for any act or omission of a broker, provider, or purchaser arising out of or in connection with the life settlement transaction, unless the insurer receives compensation for the placement of the life settlement contract from the provider, purchaser, or broker in connection with the life settlement contract.

(12) No insurer may, as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy pursuant to a life settlement contract, require that the owner, insured, provider, or broker sign any form, disclosure, consent, waiver, or acknowledgment that has not been expressly approved by the ***commissioner***~~[executive director]~~ for use in connection with life settlement contracts in the Commonwealth.

➔Section 1191. KRS 304.15-705 is amended to read as follows:

(1) The ***commissioner***~~[executive director]~~ may, when the ***commissioner***~~[executive director]~~ deems it reasonably necessary to protect the interests of the public, examine the business and affairs of any licensee or applicant for a license. The ***commissioner***~~[executive director]~~ shall have the authority to order information reasonably necessary to ascertain whether the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interest of the public. The reasonable expenses incurred in conducting any examination shall be paid by the licensee or applicant.

(2) Records of all transactions of life settlement contracts shall be subject to the following:

(a) The following records of all transactions of life settlement contracts shall be maintained by the licensee for five (5) years after the death of the owner, and shall be available to the ***commissioner***~~[executive director]~~ for inspection during reasonable business hours:

1. Proposed, offered, or executed settlement contracts, underwriting documents, policy forms, and applications from the date of the proposal, offer, or execution of the settlement contract, whichever is later; and
2. All checks, drafts, or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date of the transaction.

(b) All other business records shall be kept for a period of five (5) years following creation of records, or the completion of the purpose for which records were created, whichever shall occur last.

(c) This section shall not relieve a licensed settlement provider of the obligation to produce these documents to the ***commissioner***~~[executive director]~~ after the retention period has expired if the settlement provider has retained the documents.

(d) Records required to be retained by this section shall be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of the record.

➔Section 1192. KRS 304.15-708 is amended to read as follows:

(1) When the ***department***~~[office]~~ finds that a violation presents an immediate danger to the public health, safety, or welfare that requires an immediate final order, it shall issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent.

(2) The ***department*** ~~[office]~~ may impose and collect an administrative fine not to exceed ten thousand dollars ($10,000) for each violation of a cease and desist order issued in accordance with this section.

➔Section 1193. KRS 304.15-709 is amended to read as follows:

(1) In addition to the penalties and other enforcement provisions of KRS 304.15-020, 304.15-700 to 304.15-720, 304.42-190, and 304.99-126, if any person violates any provision of KRS 304.15-020, 304.15-700 to 304.15-720, 304.42-190, and 304.99-126, or any administrative regulations promulgated under KRS 304.15-020, 304.15-700 to 304.15-720, 304.42-190, and 304.99-126, the ***department*** ~~[office]~~ may seek an injunction in Franklin Circuit Court or in the Circuit Court of the county where the person resides or has a principal place of business and may apply for temporary and permanent orders that the ***department*** ~~[office]~~ determines necessary to restrain the person from committing the violation.

(2) Any person damaged by the acts of a person in violation of any provision of KRS 304.15-020, 304.15-700 to 304.15-720, 304.42-190, and 304.99-126 may bring a civil action against the person in the Circuit Court of the county in which the alleged violator resides, or has a principal place of business, or in the county where the alleged violation occurred.

➔Section 1194. KRS 304.15-710 is amended to read as follows:

(1) With each application for a life settlement contract, a life settlement provider or life settlement broker shall provide the owner a copy of the ***department's*** ~~[office's]~~ consumer guide relating to life settlements. The provider shall provide in writing, in a separate document that is signed by the owner and provider the information in this subsection to the owner no later than the date the life settlement contract is signed by all parties. The written disclosures shall be conspicuously displayed in any life settlement contract or in a separate document furnished to the owner by a provider including any affiliations or contractual arrangements between the provider and the

broker and shall provide the following information:

(a) That there are possible alternatives to life settlement contracts including but not limited to accelerated benefits or policy loans offered under the owner's policy;

(b) That some or all of the proceeds of the life settlement may be taxable under federal income tax laws and state franchise and income tax laws, and that assistance should be sought from a personal tax advisor;

(c) That proceeds of the life settlement contract could be subject to the claims of creditors;

(d) That receipt of the proceeds of a life settlement contract may adversely affect the owner's eligibility for Medicaid or other government benefits or entitlements, and that advice should be obtained from the appropriate government agencies;

(e) That the owner has a right to rescind a life settlement contract before the earlier of thirty (30) calendar days of the date it is executed by all parties or fifteen (15) calendar days after the receipt of the proceeds of the life settlement contract by the owner. If exercised by the owner, rescission is effective only if both notice of the rescission is given, and within the rescission period all proceeds, and any premiums, loans, and loan interest are repaid to the settlement provider. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all life settlement proceeds and any premiums, loans, and loan interest to the life settlement provider. The life settlement provider shall effectuate the change of ownership of the policy or certificate to the owner immediately upon effective rescission by the owner;

(f) That entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist

under the policy, to be forfeited by the owner and that assistance should be sought from a financial adviser;

(g) That funds will be sent to the owner within three (3) business days after the life settlement provider has received the insurer's or group administrator's acknowledgment that ownership of the policy has been transferred and the beneficiary has been designated pursuant to the life settlement contract;

(h) That the disclosure document shall contain the following language:

"All medical, financial, or personal information solicited or obtained by a life settlement provider or life settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the life settlement between the owner and the life settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two (2) years."; and

(i) That the insured may be contacted by the life settlement provider or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact shall be limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less.

(2) A life settlement provider shall provide the owner with at least the following disclosures no later than the date the life settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and the life settlement provider and provide the following information:

(a) State the affiliation, if any, between the life settlement provider and the issuer of the policy to be acquired pursuant to a settlement contract;

(b) State the name, address and telephone number of the life settlement provider;

(c) If a policy to be acquired pursuant to a life settlement contract has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be acquired pursuant to a settlement contract, the owner shall be informed of the possible loss of coverage on the other lives and shall be advised to consult with his insurance producer or the company issuing the policy for advice on the proposed life settlement contract;

(d) State the dollar amount of the current death benefit payable to the life settlement provider under the policy. The life settlement provider shall, if known, also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy, and the life settlement provider's interest in those benefits;

(e) State the name, business address, and telephone number of the independent third party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents;

(f) The date by which the funds will be available to the owner and the transmitter of the funds;

(g) That a consumer guide shall be delivered to owners with each application as required in this subsection;

(h) That applications and life settlement contracts shall contain the statement as required in KRS 304.15-717(2);

(i) That a broker represents exclusively the owner, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best

interests of the owner; and

(j) The fact that a change in ownership could in the future limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one (1) life.

(3) If the life settlement provider transfers ownership or changes the beneficiary of the policy, the life settlement provider shall communicate the change in ownership or beneficiary to the insured within twenty (20) days after the change.

(4) A broker shall provide the owner and the provider with at least the following disclosures no later than the date the life settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:

(a) The name, business address, and telephone number of the broker;

(b) A full, complete, and accurate description of all the offers, counter-offers, acceptances, and rejections relating to the proposed life settlement contract;

(c) The name of each broker who receives compensation and the amount of compensation received by the broker, which compensation includes anything of value paid or given to the broker in connection with the life settlement contract;

(d) A complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner. For the purposes of this paragraph, "gross offer or bid" means the total amount or value offered by the provider for the purchase of one (1) or more life insurance policies, inclusive of the commissions and fees; and

(e) The failure to provide the disclosures or rights described in this section shall be deemed an unfair trade practice.

➔Section 1195. KRS 304.15-712 is amended to read as follows:

(1) A broker or provider licensed pursuant to KRS 304.15-700 to 304.15-720 may

conduct or participate in advertisements within this state. Such advertisements shall comply with all advertising and marketing laws of this chapter or rules and administrative regulations promulgated by the ***commissioner***~~[executive director]~~ that are applicable to life insurers or to brokers, and providers licensed pursuant to this chapter.

(2) Advertisements shall be accurate, truthful, and not misleading in fact or by implication.

(3) No person or trust shall:

(a) Directly or indirectly market, advertise, solicit, or otherwise promote the purchase of a life insurance policy for the sole purpose of, or with a primary emphasis on, settling the policy; or

(b) Use the words "free," "no cost," or words of similar import in the marketing, advertising, soliciting, or otherwise promoting the purchase of a life insurance policy.

➔Section 1196. KRS 304.15-715 is amended to read as follows:

(1) A life settlement provider entering into a life settlement contract with any person shall first obtain:

(a) If the owner is insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a life settlement contract; and

(b) A document in which the insured consents to the release of his or her medical records to a life settlement provider, life insurance agent, or life settlement broker and, if the policy was issued less than two (2) years from the date of application for a life settlement contract, to the insurance company that issued the policy.

(2) The insurer shall respond to a request for verification of coverage submitted by a life settlement provider or life settlement broker not later than thirty (30) calendar

days after the date the request is received. The request for verification of coverage shall be made on a form approved by the ***commissioner*** ~~[executive director]~~. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at that time regarding the validity of the insurance contract or possible fraud, and shall provide sufficient detail of all reasons for the investigation to the life settlement provider or life settlement broker.

(3) Prior to or at the time of execution of the life settlement contract, the life settlement provider shall obtain a witnessed document in which the owner consents to the life settlement contract, represents that he or she has a full and complete understanding of the life settlement contract and a full and complete understanding of the benefits of the policy, and acknowledges that he or she has entered into the life settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, that the terminal or chronic illness or condition was diagnosed after the policy was issued.

(4) All medical information solicited or obtained by any licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information.

(5) All life settlement contracts entered into in this state shall contain an unconditional right to rescind a life settlement contract before the earlier of thirty (30) calendar days after the date it is executed or fifteen (15) calendar days after the date of receipt of the proceeds of the life settlement contract by the owner. If exercised by the owner, rescission is effective only if both notice of the rescission is given, and within the rescission period all proceeds, and any premiums, loans, and loan interest are repaid to the life settlement provider. If the insured dies during the rescission period, the life settlement contract shall be deemed to have been rescinded subject to repayment of all proceeds and any premiums, loans, and loan interest to the life

settlement provider. The life settlement provider shall effectuate the change of ownership of the policy or certificate to the owner immediately upon effective rescission by the owner.

(6) The independent third-party trustee shall transfer the proceeds that are due to the owner within two (2) business days upon receipt of acknowledgment of the transfer of ownership from the insurer.

(7) Failure to tender consideration to the owner for the life settlement contract by the date disclosed renders the life settlement contract voidable by the owner for lack of consideration until the time consideration is tendered to and accepted by the owner.

(8) Contacts with the insured for the purpose of determining the health status of the insured after the execution of the life settlement contract shall only be made by the life settlement provider or its authorized representative and shall be limited to once every three (3) months for an insured with a life expectancy of more than one (1) year, and to no more than once per month for an insured with a life expectancy of one (1) year or less. The life settlement provider shall explain the procedure for these contacts at the time the life settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Life settlement providers shall be responsible for the actions of their authorized representatives.

(9) The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered into in the Commonwealth or with a resident of the Commonwealth.

(10) If a life settlement broker performs any activities required of the provider under this section, the provider is deemed to have fulfilled those requirements of this section that have been properly performed by the broker.

(11) If a life settlement broker performs any of the disclosure activities required of the provider under KRS 304.15-710, the provider is deemed to have fulfilled those

requirements of KRS 304.15-710 that have been properly performed by the broker.

(12) Within twenty (20) days after an owner executes the life settlement contract, the provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a life settlement contract. The notice shall be accompanied by the documents required by KRS 304.15-702(1)(b).

(13) Any fee paid by a provider, party, individual, or an owner to a broker in exchange for services provided to the owner pertaining to a life settlement contract shall be computed as a percentage of the offer obtained, not the face value of the policy. Nothing in this section shall be construed as prohibiting a broker from reducing such broker's fee below this percentage if the broker so chooses.

(14) The broker shall disclose to the owner anything of value paid or given to a broker which relates to a life settlement contract.

➔Section 1197. KRS 304.15-717 is amended to read as follows:

(1) It is unlawful for any person:

(a) To knowingly or intentionally enter into a life settlement contract when the subject life insurance policy was obtained by means of a false, deceptive, or misleading application for the life insurance policy;

(b) To knowingly or intentionally interfere with the enforcement of the provisions of this subtitle or investigations of suspected or actual violations of this subtitle;

(c) To knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements as defined in KRS 304.15-020(5);

(d) To commit a fraudulent life settlement act;

(e) To misrepresent that the life settlement provider, life settlement broker, other licensee, or any other person has been guaranteed, sponsored, recommended, or approved by the state, or by any local, state, or federal agency or officer

thereof;

(f) To act as a life settlement broker if the person is acting as a life settlement provider in the same life settlement contract;

(g) For any person to pay any compensation or provide anything of value to an insured's physician, attorney, accountant, or any other person who provides medical, legal, or financial advice to the insured as a finder's or referral fee;

(h) To engage in any transaction, practice, or course of business if such person knows or reasonably should have known that the intent was to avoid the notice requirements of KRS 304.15-020 and 304.15-700 to 304.15-720;

(i) To engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an owner who is a resident of this state;

(j) To issue, solicit, market, or otherwise promote the purchase of a life insurance policy for the sole purpose of or with a primary emphasis on settling the policy;

(k) To enter into a life settlement contact on a policy that was the subject of a premium finance agreement as described in KRS 304.15-020(17)(b)2.;

(l) With respect to any life settlement contract or life insurance policy and a broker, to knowingly solicit an offer from, effectuate a life settlement contract with or make a sale to any provider, financing entity, or related provider trust, or any insurer that is controlling, controlled by, or under common control with such broker unless disclosed to the owner;

(m) With respect to any life settlement contract or life insurance policy and a provider, to knowingly enter into a life settlement contract with an owner if, in connection with such life settlement contract, anything of value will be paid to a broker or provider that is controlling, controlled by, or under common control with such provider, the financing entity, or related provider trust that is involved in such life settlement, or any insurer unless disclosed to the owner;

(n) With respect to a provider, to enter into a life settlement contract unless the life settlement promotional, advertising, and marketing materials, as may be prescribed by administrative regulation, have been filed with the ***commissioner***~~[executive director]~~. Marketing materials shall not expressly reference that the insurance is "free" for any period of time. The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time shall be considered a violation of KRS 304.15-700 to 304.15-720;

(o) With respect to any insurance company, insurance producer, broker, or provider, or any other person, to make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy; or

(p) If an insurer, to:

1. Engage in or permit any discrimination between individuals of the same class, same policy amount, and equal expectation of life in the rates charged for any life insurance policy or annuity contract based upon an individual's having entered into a life settlement contract or being insured under a settled policy;
2. Make any false or misleading statement as to the business of life settlements or financing premiums due for a policy or to any owner or insured for the purpose of inducing or tending to induce the owner or insured not to enter into a life settlement contract; or
3. Engage in any transaction, act, practice, or course of business, or dealing which restricts, limits, or impairs in any way the lawful transfer of ownership, change of beneficiary, or assignment of a policy.

This subsection shall not prohibit a statement that the person is licensed, if that

statement is true and the effect of the statement is not misrepresented.

(2) A life settlement contract and an application for a life settlement contract, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and upon conviction may be subject to fines or confinement in prison, or both."

The lack of a statement required by this section does not constitute a defense in any prosecution for a fraudulent life settlement act.

(3) (a) A person engaged in the business of life settlements who has knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed shall provide the information required to the ***commissioner***~~[executive director]~~, in a manner prescribed by the ***commissioner***~~[executive director]~~.

(b) Any person who has knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed may provide the information required to the ***commissioner***~~[executive director]~~, in a manner prescribed by the ***commissioner***~~[executive director]~~ in administrative regulations.

(4) (a) Civil liability may not be imposed on and a cause of action may not arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent life settlement acts, or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

1. The ***commissioner***~~[executive director]~~ or the ***commissioner's***~~[executive director's]~~ employees, agents, or representatives;

2. Federal, state, or local law enforcement or regulatory officials, or their employees, agents, or representatives;

3. A person involved in the prevention and detection of fraudulent life settlement acts or that person's agents, employees, or representatives;

4. The National Association of Insurance Commissioners (NAIC), the National Association of Securities Dealers (NASD), the North American Securities Administrators Association (NASAA), or their employees, agents, or representatives, or any other regulatory body overseeing life insurance or life settlement contracts;

5. The insurer that issued the policy covering the life of the insured; or

6. The licensee and any agents, employees, or representatives.

(b) This subsection shall not apply to a statement made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent life settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that this subsection shall not apply because the person filing the report or furnishing the information did so with actual malice.

(c) A person who furnishes information concerning fraudulent life settlement acts and who is a party in a civil cause of action for libel, slander, or another relevant tort arising out of activities in carrying out the provisions of this chapter shall be entitled to an award of attorney's fees and court costs if he is the prevailing party in the suit and the party bringing the action was not substantially justified in filing the cause of action. For purposes of this paragraph, a proceeding is "substantially justified" if a person had a reasonable basis in law or fact at the time the cause of action was initiated.

(d) This subsection shall not abrogate or modify common law or statutory privileges or immunities enjoyed by a person.

(e) This subsection shall not apply to a person who furnishes information concerning his own suspected, anticipated, or completed fraudulent life

settlement acts or suspected, anticipated, or completed fraudulent insurance acts.

(5) The documents and evidence provided pursuant to subsection (4) of this section or obtained by the ***commissioner***~~[executive director]~~ in an investigation of suspected or actual fraudulent life settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action, except that:

(a) This subsection shall not prohibit release by the ***commissioner***~~[executive director]~~ of documents and evidence obtained in an investigation of suspected or actual fraudulent life settlement acts:

1. In administrative or judicial proceedings to enforce laws administered by the ***commissioner***~~[executive director]~~;

2. To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent life settlement acts, or to the National Association of Insurance Commissioners (NAIC); or

3. At the discretion of the ***commissioner***~~[executive director]~~, to a person in the business of life settlements that is aggrieved by a fraudulent life settlement act.

(b) The release of documents and evidence provided by paragraph (a) of this subsection shall not abrogate or modify the privilege granted by this subsection.

(6) This section shall not:

(a) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(b) Prevent or prohibit a person from voluntarily disclosing information

concerning fraudulent life settlement acts to a law enforcement or regulatory agency other than the ***Department***~~[Office]~~ of Insurance;

(c) Limit the powers granted elsewhere by the laws of this state to the ***commissioner***~~[executive director]~~ or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers; or

(d) Preempt, supersede, or limit any provision of any state securities law or any rule, order, administrative regulation, or notice issued thereunder.

(7) A life settlement provider shall adopt antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. The ***commissioner***~~[executive director]~~ may order or, if a licensee requests, may grant modifications of the required initiatives listed in this subsection as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications reasonably may be expected to accomplish the purpose of this section. Antifraud initiatives shall include the following:

(a) Fraud investigators, who may be life settlement providers or employees or independent contractors of those life settlement providers; and

(b) An antifraud plan submitted to the ***commissioner***~~[executive director]~~ that shall include but is not limited to the following:

1. The procedures for detecting and investigating possible fraudulent life settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

2. The procedures for reporting possible fraudulent life settlement acts to the ***commissioner***~~[executive director]~~;

3. The plan for antifraud education and training of underwriters and other personnel; and

4. A chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent life settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

Antifraud plans submitted to the ***commissioner***~~[executive director]~~ shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

➔Section 1198. KRS 304.15-719 is amended to read as follows:

Each provider shall file with the ***commissioner***~~[executive director]~~ on or before March 1 of each year an annual statement containing such information as the ***commissioner***~~[executive director]~~ may prescribe by administrative regulation. In addition to any other requirements, the annual statement of each provider shall also include the names of the insurance companies whose policies have been settled.

➔Section 1199. KRS 304.15-720 is amended to read as follows:

The ***commissioner***~~[executive director]~~ shall have the authority to:

(1) Promulgate administrative regulations in accordance with KRS Chapter 13A implementing KRS 304.15-020 and 304.15-700 to 304.15-720;

(2) Establish standards for evaluating reasonableness of payments under life settlement contracts where the insured under the policy which is the subject of a life settlement contract is terminally or chronically ill. This authority includes but is not limited to regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy. A life settlement provider, where the insured is not terminally or chronically ill, shall pay an amount greater than the cash surrender value or accelerated death benefit then available;

(3) Establish appropriate licensing requirements and fees for agents and brokers; and

(4) Promulgate administrative regulations governing the relationship and responsibilities of an insurer and a life settlement provider, life insurance producer, and others in the business of life settlements during the period of consideration or effectuation of a life settlement contract.

➔Section 1200. KRS 304.16-110 is amended to read as follows:

No policy of group life insurance shall be delivered in this state unless it contains in substance the standard provisions as required by KRS 304.16-120 to 304.16-210, inclusive, or provisions which in the opinion of the ***commissioner***~~[executive director]~~ are more favorable to the individuals insured, or at least as favorable to such individuals and more favorable to the policyholders; except, that:

(1) Provisions set forth in KRS 304.16-170 to 304.16-210, inclusive, shall not apply to policies issued to a creditor to insure its debtors.

(2) If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the ***commissioner***~~[executive director]~~ is or are equitable to the insured persons and to the policyholder, but such nonforfeiture benefits are not required to be the same as those required for individual life insurance policies.

(3) The standard provisions required for individual life insurance policies shall not apply to group life insurance policies.

➔Section 1201. KRS 304.17-030 is amended to read as follows:

No policy of health insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this title, and complies with the following:

(1) The entire money and other considerations therefor shall be expressed therein;

(2) The time when the insurance takes effect and terminates shall be expressed therein;

(3) It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two (2) or more eligible

members of that family, including husband, wife, unmarried dependent children to age nineteen (19), unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support, and any other person dependent upon the policyholder as provided pursuant to KRS 304.17-310;

(4) The style, arrangement, and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten (10) point with a lower case unspaced alphabet length not less than one hundred and twenty (120) point (the "text" shall include all printed matter except the name and address of the insurer, name on title of the policy, the brief description, if any, and captions and subcaptions);

(5) The exceptions and reductions of indemnity shall be set forth in the policy and other than those contained in KRS 304.17-050 to 304.17-290, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with the benefit provision to which it applies;

(6) Each form, including riders and indorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the

commissioner~~[executive director]~~.

➔Section 1202. KRS 304.17-040 is amended to read as follows:

(1) Except as provided in subsection (2) of this section, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in KRS 304.17-050 to 304.17-160, inclusive, in the words in which the same appear; except, that the insurer may at its option, substitute for one (1) or more of such provisions corresponding provisions of different wording approved by the ***commissioner***~~[executive director]~~ which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded individually by the applicable caption shown, or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the ***commissioner***~~[executive director]~~ may approve.

(2) If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the ***commissioner***~~[executive director]~~, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

➔Section 1203. KRS 304.17-180 is amended to read as follows:

Except as provided in subsection (2) of KRS 304.17-040, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth in KRS 304.17-190 to 304.17-290, inclusive, unless such provisions are in the words in which the same appear in the applicable section, except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the ***commissioner***~~[executive director]~~ which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption or, at the option of the insurer,

by such appropriate individual or group captions or subcaptions as the ***commissioner***~~[executive director]~~ may approve.

➔Section 1204. KRS 304.17-220 is amended to read as follows:

(1) There may be a provision as follows:

"Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the like amount of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage."

(2) If the foregoing policy provision is included in a policy which also contains the policy provision set out in subsection (1) of KRS 304.17-230, there shall be added to the caption of the foregoing provision the phrase "... Expense Incurred Benefits."

(3) The insurer may, at its option, include in the provision provided in subsection (1) of this section, a definition of "other valid coverage" approved as to form by the ***commissioner***~~[executive director]~~, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the

commissioner~~[executive director]~~. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying such policy provision no third-party liability coverage amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying such policy provision no third-party liability coverage shall be included as "other valid coverage."

➔Section 1205. KRS 304.17-230 is amended to read as follows:

(1) There may be a provision as follows:

"Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

(2) If the policy provision set out in subsection (1) of this section is included in a policy which also contains the policy provision set out in subsection (1) of KRS 304.17-220, there shall be added to the caption of the foregoing provisions the phrase "... Other Benefits."

(3) The insurer may, at its option, include in the provision set out in subsection (1) of this section, a definition of "other valid coverage" approved as to form by the

commissioner~~[executive director]~~, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance laws or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the ***commissioner***~~[executive director]~~. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying such policy provision no third-party liability coverage shall be included as "other valid coverage."

➔Section 1206. KRS 304.17-240 is amended to read as follows:

(1) There may be a provision as follows:

"After the loss-of-time benefit of this policy has been payable for ninety (90) days, such benefit will be adjusted, as provided below, if the total amount of unadjusted loss-of-time benefits provided in all valid loss-of-time coverage upon the insured should exceed -- % of the insured's earned income; provided, however, that if the information contained in the application discloses that the total amount of loss-of-time benefits under this policy and under all other valid loss-of-time coverage expected to be effective upon the insured in accordance with the application for this policy exceeded -- % of the insured's earned income at the time of such application, such higher percentage will be used in the place of -- %. Such adjusted loss-of-time benefit under this policy for any month shall be only such proportion of the loss-of-time benefit otherwise payable under this policy as:

(a) The product of the insured's earned income and -- % (or, if higher, the alternative percentage described at the end of the first sentence of this provision) bears to

(b) The total amount of loss-of-time benefits payable for such month under this policy and all other valid loss-of-time coverage on the insured (without giving effect of the overinsurance provision in this or any other coverage) less in both paragraphs (a) and (b) of this subsection any amount of loss-of-time benefits payable under other valid loss-of-time coverage which does not contain an 'overinsurance provision.' In making such computation, all benefits and earnings shall be converted to a consistent (insert 'weekly' if the loss-of-time benefit of this policy is payable weekly, 'monthly' if such benefit is payable monthly, etc.) basis. If the numerator of the foregoing ratio is zero (0) or is negative, no benefit shall be payable under this policy. In no event shall this provision

1. Operate to reduce the total combined amount of loss-of-time benefits for such month payable under this policy and all other valid loss-of-time coverage below the lesser of three hundred dollars ($300) and the total combined amount of loss-of-time benefits determined without giving effect to any 'overinsurance provision' nor
2. Operate to increase the amount of benefits payable under this policy above the amount which would have been paid in the absence of this provision, nor
3. Take into account or operate to reduce any benefit other than the loss-of-time benefit.

(c) For purposes of this provision:

1. 'Earned income,' except where otherwise specified, means the greater of the monthly earnings of the insured at the time disability commences

and his ***or her*** average monthly earnings for a period of two (2) years immediately preceding the commencement of such disability, and shall not include any investment income or any other income not derived from the insured's vocational activities.

2. 'Overinsurance provision' shall include this provision and any other provision with respect to any loss-of-time coverage which may have the effect of reducing an insurer's liability if the total amount of loss-of-time benefits under all coverage exceeds a stated relationship to the insured's earnings."

(2) The foregoing provision may be included only in a policy which provides a loss-of-time benefit which may be payable for at least fifty-two (52) weeks, which is issued on the basis of selective underwriting of each individual application, and for which the application includes a question designed to elicit information necessary either to determine the ratio of the total loss-of-time benefits of the insured to the insured's earned income or to determine that such ratio does not exceed the percentage of earnings, not less than sixty percent (60%), selected by the insurer and inserted in lieu of the blank factor above. The insurer may require, as part of the proof of claim, the information necessary to administer this provision. If the application indicates that other loss-of-time coverage is to be discontinued, the amount of such other coverage shall be excluded in computing the alternative percentage in the first sentence of the overinsurance provision. The policy shall include a definition of "valid loss-of-time coverage," approved as to form by the ***commissioner***~~[executive director]~~, which definition may include coverage provided by governmental agencies and by organizations subject to regulations by insurance law and by insurance authorities of this or any other state of the United States or any other country or subdivision thereof, coverage provided for such insured pursuant to any disability benefits statute or any workers' compensation or employer's liability

statute, benefits provided by labor-management trusteed plans or union welfare plans or by employer or employee benefit organizations, or by salary continuance or pension programs, and any other coverage the inclusion of which may be approved by the ***commissioner***~~[executive director]~~.

(3) If by application of any of the foregoing provisions the insurer effects a material reduction of benefits otherwise payable under the policy, the insurer shall refund to the insured any premium unearned on the policy by reason of such reduction of coverage during the policy year current and that next preceding at the time the loss commenced, subject to the insurer's right to provide in the policy that no such reduction of benefits or refund will be made unless the unearned premium to be so refunded amounts to five dollars ($5) or such larger sum as the insurer may so specify.

➔Section 1207. KRS 304.17-380 is amended to read as follows:

Each insurer issuing health insurance policies for delivery in this state shall, before use thereof, file with the ***commissioner***~~[executive director]~~ its premium rates and classification of risks pertaining to such policies. The insurer shall adhere to its rates and classifications as filed with the ***commissioner***~~[executive director]~~. The insurer may change such filings from time to time as it deems proper.

➔Section 1208. KRS 304.17-383 is amended to read as follows:

(1) No filing under KRS 304.17-380 that contains an increase in premium rates shall become effective until the ***commissioner***~~[executive director]~~ has issued an order approving the filing. The ***commissioner***~~[executive director]~~ may hold a hearing within thirty (30) days after receiving a filing under this subtitle containing a rate increase, and after the hearing shall issue a final order approving or disapproving the filing.

(2) In approving or disapproving a filing under subsection (1) of this section, the ***commissioner***~~[executive director]~~ shall consider:

(a) Whether the benefits provided are reasonable in relation to the premium charged;

(b) Previous premium rates for the policies to which the filing applies; and

(c) The effect of the increase on policyholders.

(3) The ***commissioner***~~[executive director]~~ shall notify the Attorney General in writing of the hearing and of the premium increase to be considered. The Attorney General shall be considered a party to the hearing if he ***or she*** chooses to participate.

(4) No insurer receiving the ***commissioner's***~~[executive director's]~~ approval of a filing under this section shall submit a new filing containing a rate increase for any of the same policies until at least six (6) months have elapsed following the effective date of the approved increase.

(5) At any time, the ***commissioner***~~[executive director]~~, after an administrative hearing may withdraw approval of rates previously approved under this section if he ***or she*** determines that the benefits are no longer reasonable in relation to the premium charged. Administrative hearings conducted under authority of this section shall be conducted in accordance with KRS Chapter 13B.

➔Section 1209. KRS 304.17A-005 is amended to read as follows:

As used in this subtitle, unless the context requires otherwise:

(1) "Association" means an entity, other than an employer-organized association, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance for its members and that has a constitution and bylaws;

(2) "At the time of enrollment" means:

(a) At the time of application for an individual, an association that actively markets to individual members, and an employer-organized association that actively markets to individual members; and

(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance;

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

(4) "Basic health benefit plan" means any plan offered to an individual, a small group, or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by providers licensed pursuant to KRS Chapter 312;

(5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-91(d)(3);

(6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

(7) "COBRA" means any of the following:

(a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;

(b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or

(c) 42 U.S.C. sec. 300bb;

(8) (a) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or Part B of Title XVIII of the Social Security Act;

4. Title XIX of the Social Security Act, other than coverage consisting

solely of benefits under section 1928;

5. Chapter 55 of Title 10, United States Code, including medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Chapter 55 of Title 10, United States Code, "uniformed services" means the Armed Forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code, such as the Federal Employees Health Benefit Program;

9. A public health plan as established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. sec. 2504(e)); or

11. Title XXI of the Social Security Act, such as the State Children's Health Insurance Program.

(b) This term does not include coverage consisting solely of coverage of excepted benefits as defined in subsection (14) of this section;

(9) "Dependent" means any individual who is or may become eligible for coverage under the terms of an individual or group health benefit plan because of a relationship to a participant;

(10) "Employee benefit plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and

an employee pension benefit plan as defined by ERISA;

(11) "Eligible individual" means an individual:

(a) For whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan. A period of creditable coverage under this paragraph shall not be counted if, after that period, there was a sixty-three (63) day period of time, excluding any waiting or affiliation period, during all of which the individual was not covered under any creditable coverage;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et seq.) and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) of this subsection was not terminated based on a factor described in KRS 304.17A-240(2)(a), (b), and (c);

(d) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under KRS 304.18-110, who elected the coverage; and

(e) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program;

(12) "Employer-organized association" means any of the following:

(a) Any entity that was qualified by the ***commissioner***~~[executive director]~~ as an eligible association prior to April 10, 1998, and that has actively marketed a health insurance program to its members since September 8, 1996, and which is not insurer-controlled;

(b) Any entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and that is not insurer-controlled; or

(c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee, the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation.

Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, no employer-organized association shall be treated as an association, small group, or large group under this subtitle;

(13) "Employer-organized association health insurance plan" means any health insurance plan, policy, or contract issued to an employer-organized association, or to a trust established by one (1) or more employer-organized associations, or providing coverage solely for the employees, retired employees, directors and their spouses and dependents of the members of one (1) or more employer-organized associations;

(14) "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(a) Coverage only for accident, including accidental death and dismemberment, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in administrative regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan; and

(q) Health flexible spending arrangements;

(15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

(16) "Group health plan" means a plan, including a self-insured plan, of or contributed to by an employer, including a self-employed person, or employee organization, to provide health care directly or otherwise to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families;

(17) "Guaranteed acceptance program participating insurer" means an insurer that is

required to or has agreed to offer health benefit plans in the individual market to guaranteed acceptance program qualified individuals under KRS 304.17A-400 to 304.17A-480;

(18) "Guaranteed acceptance program plan" means a health benefit plan in the individual market issued by an insurer that provides health benefits to a guaranteed acceptance program qualified individual and is eligible for assessment and refunds under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;

(19) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(20) "Guaranteed acceptance program qualified individual" means an individual who, on or before December 31, 2000:

(a) Is not an eligible individual;

(b) Is not eligible for or covered by other health benefit plan coverage or who is a spouse or a dependent of an individual who:

1. Waived coverage under KRS 304.17A-210(2); or

2. Did not elect family coverage that was available through the association or group market;

(c) Within the previous three (3) years has been diagnosed with or treated for a high-cost condition or has had benefits paid under a health benefit plan for a high-cost condition, or is a high risk individual as defined by the underwriting criteria applied by an insurer under the alternative underwriting mechanism established in KRS 304.17A-430(3);

(d) Has been a resident of Kentucky for at least twelve (12) months immediately preceding the effective date of the policy; and

(e) Has not had his or her most recent coverage under any health benefit plan terminated or nonrenewed because of any of the following:

1. The individual failed to pay premiums or contributions in accordance

with the terms of the plan or the insurer had not received timely premium payments;

2. The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage; or

3. The individual engaged in intentional and abusive noncompliance with health benefit plan provisions;

(21) "Guaranteed acceptance plan supporting insurer" means either an insurer, on or before December 31, 2000, that is not a guaranteed acceptance plan participating insurer or is a stop loss carrier, on or before December 31, 2000, provided that a guaranteed acceptance plan supporting insurer shall not include an employer-sponsored self-insured health benefit plan exempted by ERISA;

(22) "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, short-term coverage, student health insurance offered by a Kentucky-licensed insurer under written contract with

a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, or limited health service benefit plans;

(23) "Health care provider" or "provider" means any facility or service required to be licensed pursuant to KRS Chapter 216B, pharmacist as defined pursuant to KRS Chapter 315, and any of the following independent practicing practitioners:

(a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;

(b) Chiropractors licensed under KRS Chapter 312;

(c) Dentists licensed under KRS Chapter 313;

(d) Optometrists licensed under KRS Chapter 320;

(e) Physician assistants regulated under KRS Chapter 311;

(f) Advanced registered nurse practitioners licensed under KRS Chapter 314; and

(g) Other health care practitioners as determined by the ***department***~~[office]~~ by administrative regulations promulgated under KRS Chapter 13A;

(24) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance Program, means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the ***commissioner***~~[executive director]~~ in accordance with KRS 304.17A-280, but only to the extent that the condition exceeds the numerical score or rating established pursuant to uniform underwriting standards prescribed by the ***commissioner***~~[executive director]~~ under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

(b) The ***commissioner***~~[executive director]~~ by administrative regulation shall establish uniform underwriting standards and a score or rating above which a condition is considered to be high-cost by using:

1. Codes in the most recent version of the "International Classification of Diseases" that correspond to the medical conditions in paragraph (c) of this subsection and the costs for administering treatment for the conditions represented by those codes; and

2. The most recent version of the questionnaire incorporated in a national underwriting guide generally accepted in the insurance industry as designated by the ***commissioner*** ~~[executive director]~~, the scoring scale for which shall be established by the ***commissioner*** ~~[executive director]~~.

(c) The diagnosed medical conditions are: acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease;

(25) "Index rate" means, for each class of business as to a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(26) "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan. The individual market includes an association plan that is not employer related, issued to individuals on an individually underwritten basis, other than an employer-organized association or a bona fide association, that has been organized and is maintained in good faith for purposes other than obtaining insurance for its members and that has a constitution and bylaws;

(27) "Insurer" means any insurance company; health maintenance organization; self-

insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

(28) "Insurer-controlled" means that the ***commissioner*** ~~[executive director]~~ has found, in an administrative hearing called specifically for that purpose, that an insurer has or had a substantial involvement in the organization or day-to-day operation of the entity for the principal purpose of creating a device, arrangement, or scheme by which the insurer segments employer groups according to their actual or anticipated health status or actual or projected health insurance premiums;

(29) "Kentucky Access" has the meaning provided in KRS 304.17B-001(17);

(30) "Large group" means:

(a) An employer with fifty-one (51) or more employees; or

(b) An affiliated group with fifty-one (51) or more eligible members;

(31) "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services and that integrate the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards for furnishing a comprehensive set of health care services and financial incentives for covered persons using the participating providers and procedures provided for in the plan;

(32) "Market segment" means the portion of the market covering one (1) of the following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

(33) "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of the employer or members of the organization, or whose beneficiaries may be eligible to receive any benefit as established in Section 3(7) of ERISA;

(34) "Preventive services" means medical services for the early detection of disease that are associated with substantial reduction in morbidity and mortality;

(35) "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals;

(36) "Provider-sponsored integrated health delivery network" means any provider-sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

(37) "Purchaser" means an individual, organization, employer, association, or the Commonwealth that makes health benefit purchasing decisions on behalf of a group of individuals;

(38) "Rating period" means the calendar period for which premium rates are in effect. A rating period shall not be required to be a calendar year;

(39) "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

(40) "Self-insured plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for covered services provided to its enrollees;

(41) "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two

(2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(42) "Small group" means:

(a) A small employer with two (2) to fifty (50) employees; or

(b) An affiliated group or association with two (2) to fifty (50) eligible members;

(43) "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

(44) "Telehealth" has the meaning provided in KRS 311.550.

➔Section 1210. KRS 304.17A-071 is amended to read as follows:

(1) The Kentucky Health Purchasing Alliance created under this subtitle shall not issue or renew any business after June 1, 1998. The ***commissioner*** ~~[executive director]~~ shall take necessary and appropriate actions to terminate all activities of the alliance no later than June 30, 1999, and shall provide assistance to persons who are members of the alliance in obtaining health insurance coverage in the private market. KRS 304.17A-010 to 304.17A-070 shall become null and void on July 1, 1999.

(2) No health benefit plans shall be issued, delivered, or renewed under the provisions of KRS 304.17A-110, 304.17A-120, and 304.17A-160 on or after June 30, 1998. Health benefit plans in effect on April 10, 1998, shall be subject to the provisions of KRS 304.17A-110, 304.17A-120, and 304.17A-160 until the end of the contract or policy period. The provisions of KRS 304.17A-110, 304.17A-120, and 304.17A-160 shall become null and void on July 1, 1999.

➔Section 1211. KRS 304.17A-080 is amended to read as follows:

(1) There is hereby created and established a Health Insurance Advisory Council whose duties shall be to review and discuss with the ***commissioner*** ~~[executive director]~~ any issues which impact the provision of health insurance in the state. The advisory council shall consist of nine (9) members: the ***commissioner*** ~~[executive director]~~

plus eight (8) persons appointed by the Governor with the advice of the ***commissioner***~~[executive director]~~ to serve two (2) year terms. The ***commissioner***~~[executive director]~~ shall serve as chair of the advisory council.

(2) The eight (8) persons appointed by the Governor with the advice of the ***commissioner***~~[executive director]~~ shall be:

(a) Two (2) representatives of insurers currently offering health benefit plans in the state;

(b) Two (2) practicing health care providers;

(c) Two (2) representatives of purchasers of health benefit plans; and

(d) Two (2) representatives of agents.

(3) The council shall:

(a) Review and discuss the design of the standard health benefit plan;

(b) Review and discuss the rate-filing process for all health benefit plans;

(c) Review and discuss the administrative regulations concerning this subtitle to be promulgated by the ***department***~~[office]~~;

(d) Make recommendations on high-cost conditions as provided in KRS 304.17B-033;

(e) Advise the ***Department***~~[Office]~~ of Insurance concerning the ***Department***~~[Office]~~ of Insurance's separation plan for the division of duties and responsibilities between the operation of the ***Department***~~[Office]~~ of Insurance and the operation of Kentucky Access;

(f) Review and discuss issues that impact Kentucky Access; and

(g) Review and discuss other issues at the request of the ***commissioner***~~[executive director]~~.

(4) The advisory council shall be a budgetary unit of the ***department***~~[office]~~ which shall pay all of the advisory council's necessary operating expenses and shall furnish all office space, personnel, equipment, supplies, and technical or administrative

services required by the advisory council in the performance of the functions established in this section.

➔Section 1212. KRS 304.17A-095 is amended to read as follows:

(1) (a) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to any market segment other than a large group shall, before use thereof, file with the ***commissioner***~~[executive director]~~ its rates, fees, dues, and other charges paid by insureds, members, enrollees, or subscribers. The insurer shall also submit a copy of the filing to the Attorney General and shall comply with the provisions of this section. The insurer shall adhere to its rates, fees, dues, and other charges as filed with the ***commissioner***~~[executive director]~~. The insurer shall submit a new filing to reflect any material change to the previously filed and approved rate filing. For all other changes, the insurer shall submit an amendment to a previously approved rate filing.

(b) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to a large group as defined in KRS 304.17A-005 shall file the rating methodology with the ***commissioner***~~[executive director]~~ and shall submit a copy of the filing to the Attorney General.

(2) (a) A rate filing under this section may be used by the insurer on and after the date of filing with the ***commissioner***~~[executive director]~~ prior to approval by the ***commissioner***~~[executive director]~~. A rate filing shall be approved or disapproved by the ***commissioner***~~[executive director]~~ within sixty (60) days after the date of filing. Should sixty (60) days expire after the ***commissioner***~~[executive director]~~ receives the filing before approval or disapproval of the filing, the filing shall be deemed approved.

(b) In the circumstances of a filing that has been deemed approved or has been

disapproved under paragraph (a) of this subsection, the ***commissioner***~~[executive director]~~ shall have the authority to order a retroactive reduction of rates to a reasonable rate if the ***commissioner***~~[executive director]~~ subsequently determines that the filing contained misrepresentations or was based on fraudulent information, and if after applying the factors in subsection (3) of this section the ***commissioner***~~[executive director]~~ determines that the rates were unreasonable. If the ***commissioner***~~[executive director]~~ seeks to order a retroactive reduction of rates and more than one (1) year has passed since the date of the filing, the ***commissioner***~~[executive director]~~ shall consider the reasonableness of the rate over the entire period during which the filing has been in effect.

(3) In approving or disapproving a filing under this section, the ***commissioner***~~[executive director]~~ shall consider:

(a) Whether the benefits provided are reasonable in relation to the premium or fee charged;

(b) Whether the fees paid to providers for the covered services are reasonable in relation to the premium or fee charged;

(c) Previous premium rates or fees for the policies or contracts to which the filing applies;

(d) The effect of the rate or rate increase on policyholders, enrollees, and subscribers;

(e) Whether the rates, fees, dues, or other charges are excessive, inadequate, or unfairly discriminatory;

(f) The effect on the rates of any assessment made under KRS 304.17B-021; and

(g) Other factors as deemed relevant by the ***commissioner***~~[executive director]~~.

(4) The rates for each policyholder shall be guaranteed for twelve (12) months at the

rate in effect on the date of issue or date of renewal.

(5) At any time the ***commissioner***~~[executive director]~~, after a public hearing for which at least thirty (30) days' notice has been given, may withdraw approval of rates or fees previously approved under this section and may order an appropriate refund or future premium credit to policyholders, enrollees, and subscribers if the ***commissioner***~~[executive director]~~ determines that the rates or fees previously approved are in violation of this chapter.

(6) Notwithstanding subsection (2) of this section, premium rates may be used upon filing with the ***department***~~[office]~~ of a policy form not previously used if the filing is accompanied by the policy form filing and a minimum loss ratio guarantee. Insurers may use the filing procedure specified in this subsection only if the affected policy forms disclose the benefit of a minimum loss ratio guarantee. An insurer may not elect to use the filing procedure in this subsection for a policy form that does not contain the minimum loss ratio guarantee. If an insurer elects to use the filing procedure in this subsection for a policy form or forms, the insurer shall not use a filing of premium rates that does not provide a minimum loss ratio guarantee for that policy form or forms.

(a) The minimum loss ratio shall be in writing and shall contain at least the following:

1. An actuarial memorandum specifying the expected loss ratio that complies with the standards as set forth in this subsection;
2. A statement certifying that all rates, fees, dues, and other charges are not excessive, inadequate, or unfairly discriminatory;
3. Detailed experience information concerning the policy forms;
4. A step-by-step description of the process used to develop the experience loss ratio, including demonstration with supporting data;
5. A guarantee of a specific lifetime minimum loss ratio, that shall be

greater than or equal to the following, taking into consideration adjustments for duration as set forth in administrative regulations promulgated by the ***commissioner***~~[executive director]~~:

a. Sixty-five percent (65%) for policies issued to individuals or for certificates issued to members of an association that does not offer coverage to small employers;

b. Seventy percent (70%) for policies issued to small groups of two (2) to ten (10) employees or for certificates issued to members of an association that offers coverage to small employers; and

c. Seventy-five percent (75%) for policies issued to small groups of eleven (11) to fifty (50) employees;

6. A guarantee that the actual Kentucky loss ratio for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed, will meet or exceed the minimum loss ratio standards referred to in subparagraph 5. of this paragraph, adjusted for duration;

7. A guarantee that the actual Kentucky lifetime loss ratio shall meet or exceed the minimum loss ratio standards referred to in subparagraph 5. of this paragraph; and

8. If the annual earned premium volume in Kentucky under the particular policy form is less than two million five hundred thousand dollars ($2,500,000), the minimum loss ratio guarantee shall be based partially on the Kentucky earned premium and other credibility factors as specified by the ***commissioner***~~[executive director]~~.

(b) The actual Kentucky minimum loss ratio results for each year at issue shall be independently audited at the insurer's expense and the audit shall be filed with the ***commissioner***~~[executive director]~~ not later than one hundred twenty (120) days after the end of the year at issue. The audit shall demonstrate the

calculation of the actual Kentucky loss ratio in a manner prescribed as set forth in administrative regulations promulgated by the ***commissioner***~~[executive director]~~.

(c) The insurer shall refund premiums in the amount necessary to bring the actual loss ratio up to the guaranteed minimum loss ratio.

(d) A Kentucky policyholder affected by the guaranteed minimum loss ratio shall receive a portion of the premium refund relative to the premium paid by the policyholder. The refund shall be made to all Kentucky policyholders insured under the applicable policy form during the year at issue if the refund would equal ten dollars ($10) or more per policy. The refund shall include statutory interest from July 1 of the year at issue until the date of payment. Payment shall be made not later than one hundred eighty (180) days after the end of the year at issue.

(e) Premium refunds of less than ten dollars ($10) per insured shall be aggregated by the insurer and paid to the Kentucky State Treasury.

(f) None of the provisions of subsections (2) and (3) of this section shall apply if premium rates are filed with the ***department***~~[office]~~ and accompanied by a minimum loss ratio guarantee that meets the requirements of this subsection. Such filings shall be deemed approved. Each insurer paying a risk assessment under KRS 304.17B-021 may include the amount of the assessment in establishing premium rates filed with the ***commissioner***~~[executive director]~~ under this section. The insurer shall identify any assessment allocated.

(g) The policy form filing of an insurer using the filing procedure with a minimum loss ratio guarantee will disclose to the enrollee, member, or subscriber as prescribed by the ***commissioner***~~[executive director]~~ an explanation of the lifetime loss ratio guarantee, and the actual loss ratio, and any adjustments for duration.

(h) The insurer who elects to use the filing procedure with a minimum loss ratio guarantee shall notify all policyholders of the refund calculation, the result of the refund calculation, the percent of premium on an aggregate basis to be refunded if any, any amount of the refund attributed to the payment of interests, and an explanation of amounts less than ten dollars ($10).

(i) Notwithstanding the provisions of this subsection, an insurer may amend the policy forms used before March 31, 2005, or may amend the minimum loss ratio guarantee on policy forms filed with the ***department***~~[office]~~ and used by the insurer prior to March 31, 2005, to provide for a minimum loss ratio guarantee allowed under this subsection for policies issued, delivered, or renewed on or after March 31, 2005.

(7) The ***commissioner***~~[executive director]~~ may by administrative regulation prescribe any additional information related to rates, fees, dues, and other charges as they relate to the factors set out in subsection (3) of this section that he or she deems necessary and relevant to be included in the filings and the form of the filings required by this section. When determining a loss ratio for the purposes of loss ratio guarantee, the insurer shall divide the total of the claims incurred, plus preferred provider organization expenses, case management and utilization review expenses, plus reinsurance premiums less reinsurance recoveries by the premiums earned less state and local premium taxes less other assessments. For purposes of determining the loss ratio for any loss ratio guarantee pursuant to this section, the ***commissioner***~~[executive director]~~ may examine the insurer's expenses for preferred provider organization, case management, utilization review, and reinsurance used by the insurer in calculating the loss ratio guarantee for reasonableness. Only those expenses found to be reasonable by the ***commissioner***~~[executive director]~~ may be used by the insurer for determining the loss ratio for purposes of any loss ratio guarantee.

(8) (a) The ***commissioner***~~[executive director]~~ shall hold a hearing upon written request by the Attorney General. The written request shall be based upon one (1) or more of the reasons set out in subsection (3) of this section and shall state the applicable reasons.

(b) An insurer may request a hearing, pursuant to KRS 304.2-310, with regard to any action taken by the ***commissioner***~~[executive director]~~ under this section as to the disapproval of rates or an order of a retroactive reduction of rates.

(c) The hearing shall be a public hearing conducted in accordance with KRS 304.2-310.

➔Section 1213. KRS 304.17A-0952 is amended to read as follows:

Premium rates for a health benefit plan issued or renewed to an individual, a small group, or an association on or after April 10, 1998, shall be subject to the following provisions:

(1) The premium rates charged during a rating period to an individual with similar case characteristics for the same coverage, or the rates that could be charged to that individual under the rating system for that class of business, shall not vary from the index rate by more than thirty-five percent (35%) of the index rate upon any policy issuance or renewal, on or after January 1, 2003.

(2) Notwithstanding the thirty-five percent (35%) variance limitation in subsection (1) of this section, insurers offering an individual health benefit plan that is state-elected under sec. 35(e)(1)F of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201, may vary from the index rate by more than thirty-five percent (35%) for individuals who are eligible for the health coverage tax credit under the following conditions:

(a) The insurer certifies that the individual does not meet the insurer's underwriting guidelines for issuance of an individual policy;

(b) The policy meets the requirements for state-elected coverage under the Trade Act of 2002; and

(c) The premium rate is actuarially justified and has been approved by the ***Department*** ~~[Office]~~ of Insurance pursuant to KRS 304.17A-095.

(3) The percentage increase in the premium rate charged to an individual for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

(b) Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the individual and dependents as determined from the insurer's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the insurer's rate manual for the class of business.

(4) The premium rates charged during a rating period to a small group or to an association member with similar case characteristics for the same coverage, or the rates that could be charged to that small group or that association member under the rating system for that class of business, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

(5) The percentage increase in the premium rate charged to a small group or to an association member for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In

the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

(b) Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the employee, association member, or dependents as determined from the insurer's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small group or association member as determined from the insurer's rate manual for the class of business.

(6) In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area.

(7) Adjustments in rates for claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, health status, and duration of coverage shall not be charged to an individual group member or the member's dependents. Any adjustment shall be applied uniformly to the rates charged for all individuals and dependents of the small group.

(8) The ***commissioner***~~[executive director]~~ may approve establishment of additional classes of business upon application to the ***commissioner***~~[executive director]~~ and a finding by the ***commissioner***~~[executive director]~~ that the additional class would enhance the efficiency and fairness for the applicable market segment.

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business in that market segment by more than ten percent (10%).

(b) An insurer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative cost related to the following reasons:

1. The insurer uses more than one (1) type of system for the marketing and sale of the health benefit plans;
2. The insurer has acquired a class of business from another insurer; or
3. The insurer is offering a state-elected plan under the provisions of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201.

(c) Notwithstanding any other provision of this subsection, beginning January 1, 2001, a GAP participating insurer may establish a separate class of business for the purpose of separating guaranteed acceptance program qualified individuals from other individuals enrolled in their plan prior to January 1, 2001. The index rate for the separate class created under this paragraph shall be established taking into consideration expected claims experience and administrative costs of the new class of business and the previous class of business.

(9) For the purpose of this section, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize a restricted provider network if utilization of the restricted provider network results in substantial differences in claims costs.

(10) Notwithstanding any other provision of this section, an insurer shall not be required to utilize the experience of those individuals with high-cost conditions who enrolled in its plans between July 15, 1995, and April 10, 1998, to develop the insurer's index rate for its individual policies.

(11) Nothing in this section shall be construed to prevent an insurer from offering incentives to participate in a program of disease prevention or health improvement.

➔Section 1214. KRS 304.17A-0954 is amended to read as follows:

(1) For purposes of this section:

(a) "Base premium rate" has the meaning provided in KRS 304.17A-005;

(b) "Employer" means a person engaged in a trade or business who has two (2) or more employees within the state in each of twenty (20) or more calendar weeks in the current or preceding calendar year;

(c) "Employer-organized association" means any of the following:

1. Any entity which was qualified by the ***commissioner***~~[executive director]~~ as an eligible association prior to April 10, 1998, and which has actively marketed a health insurance program to its members after September 8, 1996, and which is not insurer-controlled;

2. An entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and which is not insurer-controlled; or

3. Any entity which is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation;

(d) "Index rate" has the meaning provided in KRS 304.17A-005.

(2) Notwithstanding any other provision of this chapter, the amount or rate of premiums for an employer-organized association health plan may be determined, subject to the restrictions of subsection (3) of this section, based upon the experience or projected experience of the employer-organized associations whose employers obtain group coverage under the plan. Without the written consent of the

employer-organized association filed with the ***commissioner*** ~~[executive director]~~, the index rate for the employer-organized association shall be calculated solely with respect to that employer-organized association and shall not be tied to, linked to, or otherwise adversely affected by any other index rate used by the issuing insurer.

(3) The following restrictions shall be applied in calculating the permissible amount or rate of premiums for an employer-organized health insurance plan:

(a) The premium rates charged during a rating period to members of the employer-organized association with similar characteristics for the same or similar coverage, or the premium rates that could be charged to a member of the employer-organized association under the rating system for that class of business, shall not vary from its own index rate by more than fifty percent (50%) of its own index rate.

(b) The percentage increase in the premium rate charged to an employer member of an employer-organized association for a new rating period shall not exceed the sum of the following:

1. The percentage change in the new business premium rate for the employer-organized association measured from the first day of the prior rating period to the first day of the new rating period;

2. Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating period of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the member as determined from the insurer's rate manual; and

3. Any adjustment due to change in coverage or change in the case characteristics of the member as determined by the insurer's rate manual.

(4) In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate

factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area.

(5) For the purpose of this section, a health insurance contract that utilizes a restricted provider network shall not be considered similar coverage to a health insurance contract that does not utilize a restricted provider network if utilization of the restricted provider network results in measurable differences in claims costs.

➔Section 1215. KRS 304.17A-138 is amended to read as follows:

(1) (a) A health benefit plan shall not exclude a service from coverage solely because the service is provided through telehealth and not provided through a face-to-face consultation if the consultation is provided through the telehealth network established under KRS 194A.125. A health benefit plan may provide coverage for a consultation at a site not within the telehealth network at the discretion of the insurer.

(b) A telehealth consultation shall not be reimbursable under this section if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

(2) Benefits for a service provided through telehealth required by this section may be made subject to a deductible, copayment, or coinsurance requirement. A deductible, copayment, or coinsurance applicable to a particular service provided through telehealth shall not exceed the deductible, copayment, or coinsurance required by the health benefit plan for the same service provided through a face-to-face consultation.

(3) Payment made under this section may be consistent with any provider network arrangements that have been established for the health benefit plan.

(4) The ***department*** ~~[office]~~ shall promulgate an administrative regulation in accordance with KRS Chapter 13A to designate the claim forms and records required to be

maintained in conjunction with this section.

➔Section 1216. KRS 304.17A-150 is amended to read as follows:

(1) On and after July 15, 1995, it is an unfair trade practice for an insurer, agent, broker, or any other person in the business of marketing and selling health plans, to commit or perform any of the following acts:

(a) Encourage individuals or groups to refrain from filing an application for coverage with the insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

(b) Encourage or direct individuals or groups to seek coverage from another insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

(c) Encourage an employer to exclude an employee from coverage.

The provisions of this subsection shall not apply to information provided regarding the established geographic service area of an insurer.

(2) It is an unfair trade practice for an insurer to compensate an agent, broker, or any other person in the business of marketing and selling health plans on the basis of the health status, claims experience, industry, occupation, or geographic location of the insured or prospective insured except as provided in KRS 304.17B-001 to 304.17B-031.

(3) It shall constitute an unfair trade practice for any insurer, insurance agent, or third-party administrator to refer an individual to Kentucky Access, or to arrange for an individual to apply to Kentucky Access, for the purpose of separating an individual from group health insurance coverage.

(4) It is an unfair trade practice for an insurer that offers multiple health benefit plans to require a health care provider, as a condition of participation in a health benefit plan of the insurer, to participate in any of the insurer's other health benefit plans. In addition to the proceedings and penalties provided in this chapter for violation of

this provision, a contract provision violating this subsection is void.

(5) It is an unfair trade practice for an insurer not to compute an insured's coinsurance or cost sharing on the basis of the amount actually received by a health-care provider from the insurer.

(6) The ***commissioner*** ~~[executive director]~~ may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any insurer that fails to pay an assessment under KRS 304.17B-021. As an alternative, the ***commissioner*** ~~[executive director]~~ may levy a civil penalty on any member insurer that fails to pay the assessment when due. The civil penalty shall not exceed five percent (5%) of the unpaid assessment per month, but no civil penalty shall be less than one hundred dollars ($100) per month.

(7) The remedy provided by KRS 304.12-120 shall be available for conduct proscribed by this section.

(8) It is an unfair claims settlement practice for any person to make claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made in instances in which the insured has a liability under the policy beyond his or her copayment or deductible.

➔Section 1217. KRS 304.17A-200 is amended to read as follows:

(1) An insurer that offers health benefit plan coverage in the small group, large group, or association market may not establish rules for eligibility of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or the dependent of the individual:

(a) Health status;

(b) Medical condition, including both physical and mental illness;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(h) Disability.

(2) An insurer that offers health benefit plan coverage in the small group, large group, or association market shall not require any individual to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or a dependent of the individual. Nothing in this subsection shall prevent the insurer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) Subject to subsections (4) to (7) of this section, each insurer that offers health benefit plan coverage in the small groups market shall accept every small employer that applies for coverage and shall accept for enrollment under this coverage every individual eligible for the coverage who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health benefit plan.

(a) Notwithstanding any other provision of this subsection, the insurer may establish group participation rules requiring a minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of those eligible for enrollment.

(b) The terms and participation rules of the group health benefit plan shall be uniformly applicable to small employers in the small group market.

(c) This subsection shall not apply to health benefit plan coverage offered by an insurer if the coverage is made available in the small group market only through one (1) or more bona fide associations.

(4) In the case of an insurer that offers health benefit plan coverage in the small group market through a network plan, the insurer may:

(a) Limit the employers that may apply for coverage to those with individuals who live, work, or reside in the service area of the network plan; and

(b) Within the service area of the network plan, deny coverage to employers if the insurer has demonstrated to the ***commissioner***~~[executive director]~~ that:

1. The network plan will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

2. The insurer is applying this denial uniformly to all employers.

(5) An insurer, upon denying health benefit plan coverage in any service area in accordance with subsection (4) of this section, shall not offer coverage in the small group market within the service area for a period of one hundred eighty (180) days after the date the coverage is denied.

(6) An insurer may deny health benefit plan coverage in the small group market if the insurer has demonstrated to the ***commissioner***~~[executive director]~~ that:

(a) The insurer does not have the financial reserves necessary to underwrite additional coverage; and

(b) The insurer is applying this denial uniformly to all employers in the small group market.

(7) An insurer, upon denying health benefit plan coverage in connection with group health plans in accordance with subsection (6) of this section, shall not offer coverage in the small group market for a period of one hundred eighty (180) days after the date the coverage is denied or until the insurer has demonstrated to the ***commissioner***~~[executive director]~~ that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(8) A health benefit plan issued as an individual policy to individual employees or their

dependents through or with the permission of a small employer shall be issued on a guaranteed-issue basis to all full-time employees and shall comply with the pre-existing condition provisions of KRS 304.17A-220.

(9) (a) In connection with the offering of any health benefit plan to a small employer, an insurer:

1. Shall make a reasonable disclosure to a small employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this subsection; and

2. Upon request of a small employer, provide the information described in paragraph (b) of this subsection.

(b) Subject to paragraph (c) of this subsection, with respect to an insurer offering a health benefit plan to a small employer, information described in this subsection is information concerning:

1. The provisions of the coverage concerning the insurer's right to change premium rates and the factors that may affect changes in premium rates;

2. The provisions of the health benefit plan relating to renewability of coverage;

3. The provisions of the health benefit plan relating to any preexisting condition exclusion; and

4. The benefits and premiums available under all health benefit plans for which the small employer is qualified.

(c) Information described in paragraph (b) of this subsection shall be provided to a small employer in a manner determined to be understandable by the average small employer and shall be sufficient to reasonably inform a small employer of his or her rights and obligations under the health benefit plan.

(d) An insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

➔Section 1218. KRS 304.17A-220 is amended to read as follows:

(1) All group health plans and insurers offering group health insurance coverage in the Commonwealth shall comply with the provisions of this section.

(2) Subject to subsection (8) of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a pre-existing condition exclusion only if:

(a) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date. For purposes of this paragraph:

1. Medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law; and

2. The six (6) month period ending on the enrollment date begins on the six (6) month anniversary date preceding the enrollment date;

(b) The exclusion extends for a period of not more than twelve (12) months, or eighteen (18) months in the case of a late enrollee, after the enrollment date;

(c) 1. The period of any pre-existing condition exclusion that would otherwise apply to an individual is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under subsection (3) of this section; and

2. Except for ineligible individuals who apply for coverage in the individual market, the period of any pre-existing condition exclusion that would otherwise apply to an individual may be reduced by the number of days of creditable coverage the individual has as of the effective date of coverage under the policy; and

(d) A written notice of the pre-existing condition exclusion is provided to participants under the plan, and the insurer cannot impose a pre-existing condition exclusion with respect to a participant or a dependent of the participant until such notice is provided.

(3) In reducing the pre-existing condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one (1) or more types of creditable coverage. For purposes of counting creditable coverage:

(a) If on a particular day the individual has creditable coverage from more than one (1) source, all the creditable coverage on that day is counted as one (1) day;

(b) Any days in a waiting period for coverage are not creditable coverage;

(c) Days of creditable coverage that occur before a significant break in coverage are not required to be counted; and

(d) Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred.

(4) An insurer may determine the amount of creditable coverage in another manner than established in subsection (3) of this section that is at least as favorable to the individual as the method established in subsection (3) of this section.

(5) If an insurer receives creditable coverage information, the insurer shall make a determination regarding the amount of the individual's creditable coverage and the length of any pre-existing exclusion period that remains. A written notice of the length of the pre-existing condition exclusion period that remains after offsetting for prior creditable coverage shall be issued by the insurer. An insurer may not impose any limit on the amount of time that an individual has to present a certificate or evidence of creditable coverage.

(6) For purposes of this section:

(a) "Pre-existing condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a health benefit plan;

(b) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the employer changes its group health insurer, the individual's enrollment date does not change;

(c) "First day of coverage" means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract;

(d) "Late enrollee" means an individual whose enrollment in a plan is a late enrollment;

(e) "Late enrollment" means enrollment of an individual under a group health plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

2. Through special enrollment;

(f) "Significant break in coverage" means a period of sixty-three (63) consecutive days during each of which an individual does not have any creditable

coverage; and

(g) "Waiting period" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on:

1. If the application results in coverage, the date coverage begins; or

2. If the application does not result in coverage, the date on which the application is denied by the insurer or the date on which the offer of coverage lapses.

(7) (a) 1. Except as otherwise provided under subsection (3) of this section, for purposes of applying subsection (2)(c) of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

2. A group health plan, or a health insurance insurer offering group health insurance coverage, may elect to apply subsection (2)(c) of this section based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election, a group health plan or insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within this class or category.

3. In the case of an election with respect to a group health plan under subparagraph 2. of this paragraph, whether or not health insurance

coverage is provided in connection with the plan, the plan shall:

a. Prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made this election; and

b. Include in these statements a description of the effect of this election.

(b) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (9) of this section or in such other manner as may be specified in administrative regulations.

(8) (a) Subject to paragraph (e) of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion on a child who, within thirty (30) days after birth, is covered under any creditable coverage. If a child is enrolled in a group health plan or other creditable coverage within thirty (30) days after birth and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child.

(b) Subject to paragraph (e) of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion on a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, within thirty (30) days after the adoption or placement for adoption, is covered under any creditable coverage. If a child is enrolled in a group health plan or other creditable coverage within thirty (30) days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any

pre-existing condition exclusion on the child. This shall not apply to coverage before the date of the adoption or placement for adoption.

(c) A group health plan may not impose any pre-existing condition exclusion relating to pregnancy.

(d) A group health plan may not impose a pre-existing condition exclusion relating to a condition based solely on genetic information. If an individual is diagnosed with a condition, even if the condition relates to genetic information, the insurer may impose a pre-existing condition exclusion with respect to the condition, subject to other requirements of this section.

(e) Paragraphs (a) and (b) of this subsection shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any creditable coverage.

(9) (a) 1. A group health plan, and a health insurance insurer offering group health insurance coverage, shall provide a certificate of creditable coverage as described in subparagraph 2. of this subsection. A certificate of creditable coverage shall be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the following events:

a. At the time an individual ceases to be covered under a health benefit plan or otherwise becomes eligible under a COBRA continuation provision;

b. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision; and

c. On request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subdivision a. or b. of this subparagraph, whichever is

later.

The certificate of creditable coverage as described under subdivision a. of this subparagraph may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

2. The certification described in this subparagraph is a written certification of:

a. The period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the COBRA continuation provision; and

b. The waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

3. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance insurer offering the coverage provides for the certification in accordance with this paragraph.

(b) In the case of an election described in subsection (7)(a)2. of this section by a group health plan or health insurance insurer, if the plan or insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (a) of this subsection:

1. Upon request of that plan or insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or insurer information on coverage of classes and categories of health benefits available under the entity's plan or

coverage; and

2. The entity may charge the requesting plan or insurer for the reasonable cost of disclosing this information.

(10) (a) A group health plan, and a health insurance insurer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible but not enrolled for coverage under the terms of the plan, or a dependent of that employee if the dependent is eligible but not enrolled for coverage under these terms, to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at that time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or insurer, if applicable, required that statement at that time and provided the employee with notice of the requirement, and the consequences of the requirement, at that time;

3. The employee's or dependent's coverage described in subparagraph 1. of this paragraph:

a. Was under a COBRA continuation provision and the coverage under that provision was exhausted; or

b. Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, cessation of dependent status, such as obtaining the maximum age to be eligible as a dependent child, death of the employee, termination of employment, reduction in the number of hours of employment,

employer contributions toward the coverage were terminated, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, or a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or

c. Was offered through a health maintenance organization or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area and, loss of coverage in the group market occurred because an individual no longer resides, lives, or works in the service area, whether or not within the choice of the individual, and no other benefit package is available to the individual; and

4. An insurer shall allow an employee and dependent a period of at least thirty (30) days after an event described in this paragraph has occurred to request enrollment for the employee or the employee's dependent. Coverage shall begin no later than the first day of the first calendar month beginning after the date the insurer receives the request for special enrollment.

(b) A dependent of a current employee, including the employee's spouse, and the employee each are eligible for enrollment in the group health plan subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee if the requirements of paragraph (a) of this subsection are satisfied.

(c) 1. If:

a. A group health plan makes coverage available with respect to a dependent of an individual;

b. The individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan

and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

c. A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption;

the group health plan shall provide for a dependent special enrollment period described in subparagraph 2. of this paragraph during which the person or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

2. A dependent special enrollment period under this subparagraph shall be a period of at least thirty (30) days and shall begin on the later of:

a. The date dependent coverage is made available; or

b. The date of the marriage, birth, or adoption or placement for adoption, as the case may be, described in subparagraph 1.c. of this paragraph.

3. If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period, the coverage of the dependent shall become effective:

a. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

b. In the case of a dependent's birth, as of the date of the birth; or

c. In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) At or before the time an employee is initially offered the opportunity to enroll

in a group health plan, the employer shall provide the employee with a notice of special enrollment rights.

(11) (a) In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

1. No pre-existing condition exclusion is imposed with respect to coverage through the organization;
2. The period is applied uniformly without regard to any health status-related factors; and
3. The period does not exceed two (2) months, or three (3) months in the case of a late enrollee.

(b) 1. For purposes of this section, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during this period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

2. This period shall begin on the enrollment date.

3. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(c) A health maintenance organization described in paragraph (a) of this subsection may use alternative methods other than those described in that paragraph to address adverse selection as approved by the ***commissioner***~~[executive director]~~.

➔Section 1219. KRS 304.17A-230 is amended to read as follows:

(1) A health insurer offering individual health benefit plan coverage in the individual market in the Commonwealth shall not impose any pre-existing conditions exclusions as to any eligible individual.

(2) Each health insurer offering individual health benefit plan coverage in the individual market in the Commonwealth that chooses to impose a pre-existing conditions exclusion on individuals who do not meet the definition of eligible individual shall comply with the provisions of KRS 304.17A-220, which establishes standards and requirements for pre-existing conditions exclusions for group health plans, including crediting previous coverage, and certification of coverage. Pregnancy may be considered to be a pre-existing condition.

(3) Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the information.

(4) The ***Department*** ~~[Office]~~ of Insurance shall promulgate administrative regulations necessary to carry out the provisions of this section and KRS 304.17A-220.

➔Section 1220. KRS 304.17A-240 is amended to read as follows:

(1) Except as provided in this section, an insurer shall renew or continue in force a health benefit plan at the option of the insured.

(2) An insurer may nonrenew, cancel, or discontinue a health benefit plan based only on one (1) or more of the following:

(a) The insured has failed to pay premiums or contributions in accordance with the terms of the plan or the insurer has not received timely premium payments;

(b) The insured has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(c) The insured has engaged in intentional and abusive noncompliance with material provisions of the health benefit plan;

(d) The insurer is ceasing to offer coverage in the individual or group market in

accordance with subsection (3) of this section;

(e) In the case of an insurer that offers health benefit plans through a network plan, the individual no longer resides, lives, or works in the service area or in an area for which the insurer is authorized to do business, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals, or there is no longer any enrollee in connection with the group plan who resides, lives, or works in the service area of the insurer;

(f) In the case of a health benefit plan that is made available only through one (1) or more bona fide associations, the membership of the individual or employer in the association on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

(g) In the case of a health benefit plan issued to a group, the group no longer meets participation requirements or contribution requirements as established by the insurer.

(3) (a) In any case in which an insurer decides to discontinue offering a particular type of health benefit plan, coverage of the type may be discontinued by the insurer upon approval by the ***commissioner***~~[executive director]~~ only if:

1. The insurer provides notice to each insured provided coverage of this type in the market of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage;

2. The insurer offers, to each insured provided coverage of this type, the option to purchase any other health benefit plan currently of that type being offered by the insurer in that market; and

3. In exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph 2. of this paragraph,

the insurer acts uniformly without regard to any health status-related factor of enrolled insureds or insureds who may become eligible for coverage.

(b) 1. Subject to paragraph (a)3. of this subsection, in any case in which an insurer elects to discontinue offering all health benefit plans in Kentucky, health benefit plans may be discontinued by the insurer only if:

a. The insurer provides notice to the ***commissioner***~~[executive director]~~ and to each insured of the discontinuation at least one hundred eighty (180) days prior to the date of the expiration of the coverage; and

b. All health benefit plans issued or delivered for issuance in Kentucky are discontinued and coverage under the health benefit plans is not renewed.

2. In the case of a discontinuation under subparagraph 1. of this paragraph, the insurer may not provide for the issuance of any health benefit plans in Kentucky during the five (5) year period beginning on the date of the discontinuation of the last health benefit plan not so renewed.

(4) At the time of coverage renewal, an insurer may modify, with approval of the ***commissioner***~~[executive director]~~, the health benefit plan for a policy form so long as the modification is consistent with this chapter and effective on a uniform basis among all individuals with that policy form.

(5) In applying this section in the case of a health benefit plan that is made available by an insurer only through one (1) or more associations, a reference to an individual is deemed to include a reference to an association of which the individual is a member, and a reference to an employer member is deemed to include a reference to the employer.

➔Section 1221. KRS 304.17A-250 is amended to read as follows:

(1) The ***commissioner***~~[executive director]~~ shall, by administrative regulations promulgated under KRS Chapter 13A, define one (1) standard health benefit plan. After July 15, 2004, insurers may offer the standard health benefit plan in the individual or small group markets. Except as may be necessary to coordinate with changes in federal law, the ***commissioner***~~[executive director]~~ shall not alter, amend, or replace the standard health benefit plan more frequently than annually.

(2) If offered, the standard health benefit plan may be available in at least one (1) of these four (4) forms of coverage:

(a) A fee-for-service product type;

(b) A health maintenance organization type;

(c) A point-of-service type; and

(d) A preferred provider organization type.

(3) The standard health benefit plan shall be defined so that it meets the requirements of KRS 304.17B-021 for inclusion in calculating assessments and refunds under Kentucky Access.

(4) Any health insurer who offers the standard health benefit plan may offer the standard health benefit plan in the individual or small group markets in each and every form of coverage that the health insurer offers to sell.

(5) Nothing in this section shall be construed:

(a) To require a health insurer to offer a standard health benefit plan in a form of coverage that the health insurer has not selected;

(b) To prohibit a health insurer from offering other health benefit plans in the individual or small group markets in addition to the standard health benefit plan; or

(c) To require that a standard health benefit plan have guaranteed issue, renewability, or pre-existing condition exclusion rights or provisions that are

more generous to the applicant than the health insurer would be required to provide under KRS 304.17A-200, 304.17A-220, 304.17A.230, and 304.17A-240.

(6) All health benefit plans shall cover hospice care at least equal to the Medicare benefits.

(7) All health benefit plans shall coordinate benefits with other health benefit plans in accordance with the guidelines for coordination of benefits prescribed by the ***commissioner***~~[executive director]~~ as provided in KRS 304.18-085.

(8) Every health insurer of any kind, nonprofit hospital, medical-surgical, dental and health service corporation, health maintenance organization, or provider-sponsored health delivery network that issues or delivers an insurance policy in this state that directs or gives any incentives to insureds to obtain health care services from certain health care providers shall not imply or otherwise represent that a health care provider is a participant in or an affiliate of an approved or selected provider network unless the health care provider has agreed in writing to the representation or there is a written contract between the health care provider and the insurer or an agreement by the provider to abide by the terms for participation established by the insurer. This requirement to have written contracts shall apply whenever an insurer includes a health care provider as a part of a preferred provider network or otherwise selects, lists, or approves certain health care providers for use by the insurer's insureds. The obligation set forth in this section for an insurer to have written contracts with providers selected for use by the insurer shall not apply to emergency or out-of-area services.

(9) A self-insured plan may select any third party administrator licensed under KRS 304.9-052 to adjust or settle claims for persons covered under the self-insured plan.

(10) Any health insurer that fails to issue a premium rate quote to an individual within thirty (30) days of receiving a properly completed application request for the quote

shall be required to issue coverage to that individual and shall not impose any pre-existing conditions exclusion on that individual with respect to the coverage. Each health insurer offering individual health insurance coverage in the individual market in the Commonwealth that refuses to issue a health benefit plan to an applicant or insured with a disclosed high-cost condition as specified in KRS 304.17B-001 or for any reason, shall provide the individual with a denial letter within twenty (20) working days of the request for coverage. The letter shall include the name and title of the person making the decision, a statement setting forth the basis for refusing to issue a policy, a description of Kentucky Access, and the telephone number for a contact person who can provide additional information about Kentucky Access.

(11) If a standard health benefit plan covers services that the plan's insureds lawfully obtain from health departments established under KRS Chapter 212, the health insurer shall pay the plan's established rate for those services to the health department.

(12) No individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage shall have the option of remaining individually insured, as the policyholder may decide. This shall apply in any such situation that may arise through an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

➔Section 1222. KRS 304.17A-300 is amended to read as follows:

(1) A provider-sponsored integrated health delivery network may be created by health care providers for the purpose of providing health care services.

(2) No person shall in this Commonwealth be, act as, or hold itself out as a provider-sponsored integrated health delivery network unless it holds a certificate of filing

from the ***commissioner***~~[executive director]~~. Each provider-sponsored integrated health delivery network that seeks to offer services shall first be certified by the ***department***~~[office]~~.

(3) To qualify as a provider-sponsored integrated health delivery network, an applicant shall submit information acceptable to the ***department***~~[office]~~ to satisfactorily demonstrate that the provider-sponsored integrated health delivery network:

(a) Is licensed and in good standing with the licensure boards for participating providers;

(b) Has demonstrated the capacity to administer the health plans it is offering;

(c) Has the ability, experience, and structure to arrange for the appropriate level and type of health care services;

(d) Has the ability, policies, and procedures to conduct utilization management activities;

(e) Has the ability to achieve, monitor, and evaluate the quality and cost effectiveness of care provided by its provider network;

(f) Is financially solvent;

(g) Has the ability to assure enrollees adequate access to providers, including geographic availability and adequate numbers and types;

(h) Has the ability and procedures to monitor access to its provider network;

(i) Has a satisfactory grievance procedure and the ability to respond to enrollees' inquiries and complaints;

(j) Does not limit the participation of any health care provider in its provider network in another provider network;

(k) Has the ability and policies that allow patients to receive care in the most appropriate, least restrictive setting;

(l) Does not discriminate in enrolling members;

(m) Participates in coordination of benefits;

(n) Uses standardized electronic claims and billing processes and formats; and

(o) Discloses to the cooperative reimbursement arrangements with providers.

(4) Fees for the following services shall be paid to the ***commissioner*** ~~[executive director]~~ by every provider-sponsored integrated health delivery network, and the fees shall be the same as those for insurers as specified in Subtitle 4 of this chapter:

(a) For filing an application for a certificate of filing or amendment thereto;

(b) For filing an annual statement; and

(c) For other services deemed necessary by the ***commissioner*** ~~[executive director]~~.

(5) Provider-sponsored integrated health delivery networks shall be subject to the provisions of this subtitle, and to the following provisions of this chapter, to the extent applicable and not in conflict with the expressed provisions of this subtitle:

(a) Subtitle 1 -- Scope of Code;

(b) Subtitle 2 -- ***Commissioner of the Department of*** Insurance ~~[executive director]~~;

(c) Subtitle 3 -- Authorization of Insurers and General Requirements;

(d) Subtitle 4 -- Fees and Taxes;

(e) Subtitle 5 -- Kinds of Insurance--Limits of Risk--Reinsurance;

(f) Subtitle 6 -- Assets and Liabilities;

(g) Subtitle 7 -- Investments;

(h) Subtitle 8 -- Administration of Deposits;

(i) Subtitle 9 -- Agents, Consultants, Solicitors, and Adjusters;

(j) Subtitle 12 -- Trade Practices and Frauds;

(k) Subtitle 14 -- KRS 304.14-120 to 304.14-130 and 304.14-500 to 304.14-560;

(l) Subtitle 25 -- Continuity of Management;

(m) Subtitle 33 -- Insurers Rehabilitation and Liquidation;

(n) Subtitle 37 -- Insurance Holding Company Systems; and

(o) Subtitle 99 -- Penalties.

➔Section 1223. KRS 304.17A-310 is amended to read as follows:

To qualify as a provider-sponsored integrated health delivery network, the network shall meet the following financial solvency requirements:

(1) Maintenance of a fidelity bond or fidelity insurance in an amount not less than two hundred fifty thousand dollars ($250,000) on employees and officers, directors, and partners who receive, collect, disburse, or invest funds of the provider-sponsored network;

(2) (a) The provider-sponsored network shall have an initial net worth requirement of one million five hundred thousand dollars ($1,500,000) and shall thereafter maintain the minimum net worth required under paragraph (b) of this subsection.

(b) Every provider-sponsored network shall maintain a minimum net worth equal to the greater of:

1. One million dollars ($1,000,000);

2. Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the ***commissioner*** ~~[executive director]~~ on the first one hundred fifty million dollars ($150,000,000) of premiums and one percent (1%) of annual premiums on the premiums in excess of one hundred fifty million dollars ($150,000,000);

3. An amount equal to the sum of three (3) months' uncovered health care expenditures as reported on the most recent financial statement filed with the ***commissioner*** ~~[executive director]~~ of insurance; or

4. An amount equal to the sum of eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis and four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the ***commissioner*** ~~[executive director]~~.

(c) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the ***commissioner***~~[executive director]~~. Any interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated.

1. The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses.

2. Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the ***commissioner***~~[executive director]~~, shall not be considered a liability and shall be recorded as equity.

(3) (a) Unless otherwise provided below, each provider-sponsored network shall deposit with the ***commissioner***~~[executive director]~~ or, at the discretion of the ***commissioner***~~[executive director]~~, with any organization or trustee acceptable to the ***commissioner***~~[executive director]~~ through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the ***commissioner***~~[executive director]~~ which at all times shall have a value of not less than three hundred thousand dollars ($300,000).

(b) The deposit shall be an admitted asset of the provider-sponsored network in the determination of net worth.

(c) All income from deposits shall be an asset of the provider-sponsored network. A provider-sponsored network that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the ***commissioner***~~[executive director]~~ before being deposited or substituted.

(d) The deposit shall be used to protect the interests of the provider-sponsored network's enrollees and to assure continuation of health care services to

enrollees of a provider-sponsored network which is in rehabilitation or conservation. The ***commissioner*** ~~[executive director]~~ may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the provider-sponsored network is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of Subtitle 33 of this chapter.

(4) Every provider-sponsored network shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the provider-sponsored network is or may be liable, and to provide for the expense of adjustment or settlement of such claims.

(5) (a) Every contract between a provider-sponsored network and a participating provider of health care services shall be in writing and shall set forth that in the event the provider-sponsored network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the provider for any sums owed by the provider-sponsored network.

(b) If the participating provider contract has not been reduced to writing as required by this subsection or if the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the enrollee sums owed by the provider-sponsored network.

(6) Each provider-sponsored network shall have a plan for handling insolvency which guarantees the continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.

(7) If at any time uncovered expenditures exceed ten percent (10%) of total health care

expenditures, a provider-sponsored network shall place an uncovered expenditures insolvency deposit with the ***commissioner***~~[executive director]~~ or with any organization or trustee acceptable to the ***commissioner***~~[executive director]~~ through which a custodial or controlled account is maintained, in cash or securities that are acceptable to the ***commissioner***~~[executive director]~~. This deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the provider-sponsored network's outstanding liability for uncovered expenditures for enrollees, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. The provider-sponsored network shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this subsection. The provisions of subsection (6) of this section shall apply to the deposit required in this subsection.

➔Section 1224. KRS 304.17A-320 is amended to read as follows:

(1) No employer-organized association shall in this state self-insure in order to provide health benefit plans for its members unless it holds a certificate of filing from the ***commissioner***~~[executive director]~~.

(2) To qualify for a certificate of filing and to maintain a certificate of filing, the employer-organized association shall comply with the provisions of KRS 304.17A-800 to 304.17A-844 to the extent not in conflict with the expressed provisions of this section.

(3) Each association that holds a certificate of filing from the ***commissioner***~~[executive director]~~ shall be subject to the following:

(a) All assessments placed on insurers under KRS 304.17B-021;

(b) All rating restrictions placed on employer-organized associations under KRS 304.17A-0954;

(c) All rate review requirements placed on insurers under this subtitle;

(d) All data collection requirements placed on insurers under this subtitle; and

(e) Provisions of Subtitle 12 of this chapter that apply to health insurers.

(4) Each association that holds a certificate of filing from the ***commissioner***~~[executive director]~~ shall notify its members that health benefit plans issued to its members through the association are not protected through the Kentucky Life and Health Insurance Guaranty Association.

(5) Under the provisions of KRS 304.17A-840, the ***commissioner***~~[executive director]~~ may revoke the certificate of filing of any association. A violation of any provision of this section shall be deemed a violation of KRS 304.17A-800 to 304.17A-844 for purposes of KRS 304.17A-840.

➔Section 1225. KRS 304.17A-330 is amended to read as follows:

(1) All insurers authorized to write health insurance in this state and employer-organized associations that self-insure shall transmit at least annually by July 31 to the ***commissioner***~~[executive director]~~ the following information, in a format prescribed by the ***commissioner***~~[executive director]~~, on their insurance experience in this state for the preceding calendar year:

(a) Total premium by product type and market segment;

(b) Total enrollment by product type and market segment;

(c) Total cost of medical claims filed by product type and market segment;

(d) Total amount of medical claims paid by the insurer and insured by product type and market segment;

(e) Total policies canceled by type and the aggregate reasons therefor; and

(f) List of total health and medical services paid for, grouped by types of services and costs:

1. Total cost per health and medical service per insured group:

a. Cost paid by insurer;

b. Cost paid by insured; and

2. Number of insureds who received each service.

(2) With the approval of the ***commissioner***~~[executive director]~~, the ***department***~~[office]~~ may exempt insurers, employer-organized associations that self-insure, and health purchasing outlets from the data reporting requirements of this section if the total number of insureds is less than five hundred (500).

➔Section 1226. KRS 304.17A-340 is amended to read as follows:

(1) In no event shall more than ten percent (10%) of federal and state funds allocated to the Kentucky Children's Health Insurance Program be used for:

(a) Children's health programs other than those targeted for low-income children as defined under Title XXI of the Federal Social Security Act;

(b) Initiatives for improving the health of children except those low income children as defined under Title XXI of the Federal Social Security Act or an approved Title XXI state plan (KCHIP);

(c) Outreach activities that inform families of children who are likely to be eligible for this program or other public or private health coverage programs allowed by the Federal Social Security Act; and

(d) Other reasonable costs incurred by the state to administer the program.

(2) The ***department***~~[office]~~ shall use the insurer's or health maintenance organization's sales and marketing methods and may include the use of agents and payment of commissions, to inform families of the availability of the Kentucky Children's Health Insurance Program and assist them in obtaining coverage for children under the program.

➔Section 1227. KRS 304.17A-410 is amended to read as follows:

As used in KRS 304.17A-400 to 304.17A-480, unless the context requires otherwise:

(1) "Actual guaranteed acceptance program plan losses" means a dollar amount calculated by subtracting an insurer's guaranteed acceptance program plan claims from that insurer's guaranteed acceptance program plan premiums;

(2) "Benefits" means amounts paid by an insurer to covered lives or to third parties for the benefit of covered lives. "Benefits" do not include an insurer's administrative costs, any assessments under the plan, allocated loss adjustment expenses, reserves, or other overhead costs;

(3) "Guaranteed acceptance program plan claims" or "alternative underwriting mechanism losses" means the dollar amount of benefits actually paid by an insurer on behalf of a guaranteed acceptance plan enrollee for claims that were incurred while the individual was a guaranteed acceptance program plan enrollee or another claim measurement formula as the ***department*** ~~[office]~~ may establish by administrative regulation to measure an insurer's costs, other than administrative costs, allocated loss adjustment expenses, reserves, or other overhead costs, with respect to a program plan;

(4) "Guaranteed acceptance program plan premiums" means the dollar amount of premiums received by an insurer with respect to program plans;

(5) "Guaranteed acceptance risk adjustment process" means the process of allocating guaranteed acceptance program plan losses provided for in KRS 304.17A-460;

(6) "Group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan or through any arrangement other than through the individual market, or through a federal health benefit plan or program;

(7) "Health insurance stop-loss policy" means any policy of insurance that directly or indirectly protects, in whole or in part, an employer who self-insures health benefits covering any residents in Kentucky from the risk of paying benefits in excess of any specified amount;

(8) "Market share" means a percentage calculated by dividing an insurer's health insurance coverage premiums in both the individual and group markets by the total

amount of the health insurance coverage premiums in both the individual and group markets for all insurers;

(9) "Other coverage" means coverage under any of the following:

(a) A group plan;

(b) Part A or Part B of Title XVIII of the Social Security Act, 42 U.S.C. secs. 1995c et seq.;

(c) A state plan under Title XIX of the Social Security Act, or any successor program;

(d) Continuation coverage under any COBRA continuation provisions as defined in 42 U.S.C. sec. 300gg-91(d)(4) or under a similar program under any state law; or

(e) Any other health insurance coverage which is not individual health insurance coverage;

(10) "Premiums" means amounts paid to insurers to purchase health insurance coverage and includes all amounts paid however denominated, including, but not limited to, amounts indicated as being charged for administrative costs, allocated loss adjustment expenses, reserve or other overhead costs;

(11) "Program" means the Kentucky Guaranteed Acceptance Program;

(12) "Refund" means an amount to be paid to an insurer by the program;

(13) "Stop-loss carrier" means any person providing health insurance stop-loss coverage;

(14) "Stop-loss premiums" means amounts paid to purchase health insurance stop-loss coverage; and

(15) "Total actual guaranteed acceptance program plan losses" means a dollar amount equal to the sum of the actual program plan losses of all insurers participating in the program.

➔Section 1228. KRS 304.17A-430 is amended to read as follows:

(1) A health benefit plan shall be considered a program plan and is eligible for

inclusion in calculating assessments and refunds under the program risk adjustment process if it meets all of the following criteria:

(a) The health benefit plan was purchased by an individual to provide benefits for only one (1) or more of the following: the individual, the individual's spouse, or the individual's children. Health insurance coverage provided to an individual in the group market or otherwise in connection with a group health plan does not satisfy this criteria even if the individual, or the individual's spouse or parent, pays some or all of the cost of the coverage unless the coverage is offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;

(b) An individual entitled to benefits under the health benefit plan has been diagnosed with a high-cost condition on or before the effective date of the individual's coverage for coverage issued on a guarantee-issue basis after July 15, 1995;

(c) The health benefit plan imposes the maximum pre-existing condition exclusion permitted under KRS 304.17A-200;

(d) The individual purchasing the health benefit plan is not eligible for or covered by other coverage; and

(e) The individual is not a state employee eligible for or covered by the state employee health insurance plan under KRS Chapter 18A.

(2) Notwithstanding the provisions of subsection (1) of this section, if the total claims paid for the high-cost condition under a program plan for any three (3) consecutive years are less than the premiums paid under the program plan for those three (3) consecutive years, then the following shall occur:

(a) The policy shall not be considered to be a program plan thereafter until the first renewal of the policy after there are three (3) consecutive years in which the total claims paid under the policy have exceeded the total premiums paid

for the policy and at the time of the renewal the policy also qualifies under subsection (1) as a program plan; and

(b) Within the last six (6) months of the third year, the insurer shall provide each person entitled to benefits under the policy who has a high-cost condition with a written notice of insurability. The notice shall state that the recipient may be able to purchase a health benefit plan other than a program plan and shall also state that neither the notice nor the individual's actions to purchase a health benefit plan other than a program plan shall affect the individual's eligibility for plan coverage. The notice shall be valid for six (6) months.

(3) (a) There is established within the guaranteed acceptance program the alternative underwriting mechanism that a participating insurer may elect to use. An insurer that elects this mechanism shall use the underwriting criteria that the insurer has used for the past twelve (12) months for purposes of the program plan requirement in paragraph (b) of subsection (1) of this section for high-risk individuals rather than using the criteria established in KRS 304.17A-005(24) and 304.17A-280 for high-cost conditions;

(b) An insurer that elects to use the alternative underwriting mechanism shall make written application to the ***commissioner***~~[executive director]~~. Before the insurer may implement the mechanism, the insurer shall obtain approval of the ***commissioner***~~[executive director]~~. Annually thereafter, the insurer shall obtain the ***commissioner's***~~[executive director's]~~ approval of the underwriting criteria of the insurer before the insurer may continue to use the alternative underwriting mechanism.

➔Section 1229. KRS 304.17A-505 is amended to read as follows:

An insurer shall disclose in writing to a covered person and an insured or enrollee, in a manner consistent with the provisions of KRS 304.14-420 to 304.14-450, the terms and conditions of its health benefit plan and shall promptly provide the covered person and

enrollee with written notification of any change in the terms and conditions prior to the effective date of the change. The insurer shall provide the required information at the time of enrollment and upon request thereafter.

(1) The information required to be disclosed under this section shall include a description of:

(a) Covered services and benefits to which the enrollee or other covered person is entitled;

(b) Restrictions or limitations on covered services and benefits;

(c) Financial responsibility of the covered person, including copayments and deductibles;

(d) Prior authorization and any other review requirements with respect to accessing covered services;

(e) Where and in what manner covered services may be obtained;

(f) Changes in covered services or benefits, including any addition, reduction, or elimination of specific services or benefits;

(g) The covered person's right to the following:

1. A utilization review and the procedure for initiating a utilization review, if an insurer elects to provide utilization review;

2. An internal appeal of a utilization review made by or on behalf of the insurer with respect to the denial, reduction, or termination of a health care benefit or the denial of payment for a health care service, and the procedure to initiate an internal appeal; and

3. An external review and the procedure to initiate the external review process;

(h) Measures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider;

(i) Other information as the ***commissioner*** ~~[executive director]~~ shall require by

administrative regulation;

(j) A summary of the drug formulary, including, but not limited to, a listing of the most commonly used drugs, drugs requiring prior authorization, any restrictions, limitations, and procedures for authorization to obtain drugs not on the formulary and, upon request of an insured or enrollee, a complete drug formulary; and

(k) A statement informing the insured or enrollee that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer.

(2) The insurer shall file the information required under this section with the ***department*** ~~[office]~~.

➔Section 1230. KRS 304.17A-527 is amended to read as follows:

(1) A managed care plan shall file with the ***commissioner*** ~~[executive director]~~ sample copies of any agreements it enters into with providers for the provision of health care services. The ***commissioner*** ~~[executive director]~~ shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements shall include the following:

(a) A hold harmless clause that states that the provider may not, under any circumstance, including:

1. Nonpayment of moneys due the providers by the managed care plan,
2. Insolvency of the managed care plan, or
3. Breach of the agreement,

bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance

amounts, and amounts for noncovered services;

(b) A continuity of care clause that states that if an agreement between the provider and the managed care plan is terminated for any reason, other than a quality of care issue or fraud, the insurer shall continue to provide services and the plan shall continue to reimburse the provider in accordance with the agreement until the subscriber, dependent of the subscriber, or the enrollee is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the agreement is terminated;

(c) A survivorship clause that states the hold harmless clause and continuity of care clause shall survive the termination of the agreement between the provider and the managed care plan;

(d) A clause stating that the insurer issuing a managed care plan will, upon request of a participating provider, provide or make available to a participating provider, when contracting or renewing an existing contract with such provider, the payment or fee schedules or other information sufficient to enable the provider to determine the manner and amount of payments under the contract for the provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety (90) days prior to the effective date of the amendment pursuant to KRS 304.17A-577; and

(e) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide their licensed health care services to the subscriber, dependent of the subscriber, or enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or subscriber

or enrollee directly for the subcontracted services, the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the ***commissioner***~~[executive director]~~ in accordance with this subsection.

(2) An insurer that offers a health benefit plan that enters into any risk-sharing arrangement or subcontract agreement shall file a copy of the arrangement with the ***commissioner***~~[executive director]~~. The insurer shall also file the following information regarding the risk-sharing arrangement:

(a) The number of enrollees affected by the risk-sharing arrangement;

(b) The health care services to be provided to an enrollee under the risk-sharing arrangement;

(c) The nature of the financial risk to be shared between the insurer and entity or provider, including but not limited to the method of compensation;

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with KRS 304.17A-500 to 304.17A-590 in exercising any delegated administrative functions; and

(e) The insurer's oversight and compliance plan regarding the standards and method of review.

(3) Nothing in this section shall be construed as requiring an insurer to submit the actual financial information agreed to between the insurer and the entity or provider. The ***commissioner***~~[executive director]~~ shall have access to a specific risk sharing arrangement with an entity or provider upon request to the insurer. Financial information obtained by the ***department***~~[office]~~ shall be considered to be a trade secret and shall not be subject to KRS 61.872 to 61.884.

➔Section 1231. KRS 304.17A-545 is amended to read as follows:

(1) A managed care plan shall appoint a medical director who:

(a) Is a physician licensed to practice in this state;

(b) Is in good standing with the State Board of Medical Licensure;

(c) Has not had his or her license revoked or suspended, under KRS 311.530 to 311.620;

(d) Shall sign any denial letter required under KRS 304.17A-540; and

(e) Shall be responsible for the treatment policies, protocols, quality assurance activities, and utilization management decisions of the plan.

(2) The medical director shall ensure that:

(a) Any utilization management decision to deny, reduce, or terminate a health care benefit or to deny payment for a health care service because that service is not medically necessary shall be made by a physician, except in the case of a health care service rendered by a chiropractor or optometrist, that decision shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky;

(b) A utilization management decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the insurer for those services, unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person or the participating provider;

(c) In the case of a managed care plan, a procedure is implemented whereby participating physicians have an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and whereby other participating providers have an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice;

(d) The utilization management program is available to respond to authorization requests for urgent services and is available, at a minimum, during normal

working hours for inquiries and authorization requests for nonurgent health care services; and

(e) In the case of a managed care plan, a covered person is permitted to choose or change a primary care provider from among participating providers in the provider network and, when appropriate, choose a specialist from among participating network providers following an authorized referral, if required by the insurer, and subject to the ability of the specialist to accept new patients.

(3) A managed care plan shall develop comprehensive quality assurance or improvement standards adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of health care services. These standards shall be made available to the public during regular business hours and include:

(a) An ongoing written, internal quality assurance or improvement program;

(b) Specific written guidelines for quality of care studies and monitoring, including attention to vulnerable populations;

(c) Performance and clinical outcomes-based criteria;

(d) A procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

(e) A plan for data gathering and assessment; and

(f) A peer review process.

(4) Each managed care plan shall have a process for the selection of health care providers who will be on the plan's list of participating providers, with written policies and procedures for review and approval used by the plan.

(a) The plan shall establish minimum professional requirements for participating health care providers. An insurer may not discriminate against a provider solely on the basis of the provider's license by the state;

(b) The plan shall demonstrate that it has consulted with appropriately qualified health care providers to establish the minimum professional requirements;

(c) The plan's selection process shall include verification of each health care provider's license, history of license suspension or revocation, and liability claims history;

(d) A managed care plan shall establish a formal written, ongoing process for the reevaluation of each participating health care provider within a specified number of years after the provider's initial acceptance into the plan. The reevaluation shall include an update of the previous review criteria and an assessment of the provider's performance pattern based on criteria such as enrollee clinical outcomes, number of complaints, and malpractice actions.

(5) The ***commissioner*** ~~[executive director]~~ shall promulgate administrative regulations to establish a uniform application form and guidelines for the evaluation and reevaluation of health care providers, including psychologists, who will be on the plan's list of participating providers in accordance with subsection (4) of this section. In developing a uniform application and guidelines, the ***department*** ~~[office]~~ shall consider industry standards and guidelines adopted by the Council for Affordable Quality Healthcare. The uniform application form and guidelines shall be used by all insurers.

(6) A managed care plan shall not use a health care provider beyond, or outside of, the provider's legally authorized scope of practice.

➔Section 1232. KRS 304.17A-550 is amended to read as follows:

(1) An insurer that offers a managed care plan shall offer a health benefit plan with out-of-network benefits to every contract holder. The plan with out-of-network benefits shall allow a covered person to receive covered services from out-of-network health care providers without having to obtain a referral. The plan with out-of-network benefits may require that an enrollee pre-certify selected services and pay a higher deductible, copayment, coinsurance, excess charges and higher premium for the out-of-network benefit plan pursuant to limits established by administrative

regulations promulgated by the ***department***~~[office]~~.

(2) If the contract holder elects the out-of-network offering required under subsection (1) of this section, the insurer shall provide each enrollee with the opportunity at the time of enrollment and during the annual open enrollment period, to enroll in the out-of-network option. If the contract holder elects the out-of-network offering required under subsection (1) of this section, the insurer and the contract holder shall provide written notice of the benefit plan with out-of-network benefits to each enrollee in a plan and shall include in that notice a detailed explanation of the financial costs to be incurred by an enrollee who selects the plan.

(3) The requirement of this section shall not apply to an insurer contract which offers a managed care plan that provides health care services solely to Medicaid or Medicare recipients.

(4) Managed care plans currently licensed and doing business in Kentucky that do not yet offer benefit plans with out-of-network benefits must develop and offer those plans within three hundred sixty-five (365) days of April 10, 1998.

➔Section 1233. KRS 304.17A-560 is amended to read as follows:

(1) No insurance contract with a provider shall contain a most-favored-nation provision except where the ***commissioner***~~[executive director]~~ determines that the market share of the insurer is nominal.

(2) Nothing in this section shall be construed to prohibit a health insurer and a provider from negotiating payment rates and performance-based contract terms that would result in the health insurer receiving a rate that is as favorable, or more favorable, than the rates negotiated between a provider and other health insurance issuers.

➔Section 1234. KRS 304.17A-565 is amended to read as follows:

The ***commissioner***~~[executive director]~~ shall enforce the provisions of KRS 304.17A-500 to 304.17A-570 and shall adopt administrative regulations necessary to carry out the provisions of KRS 304.17A-500 to 304.17A-570.

➔Section 1235. KRS 304.17A-600 is amended to read as follows:

As used in KRS 304.17A-600 to 304.17A-633:

(1) (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:

1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and

2. Benefit coverage is therefore denied, reduced, or terminated.

(b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions;

(3) "Concurrent review" means utilization review conducted during a covered person's course of treatment or hospital stay;

(4) "Covered person" means a person covered under a health benefit plan;

(5) "External review" means a review that is conducted by an independent review entity which meets specified criteria as established in KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(6) "Health benefit plan" means the document evidencing and setting forth the terms and conditions of coverage of any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network policy or certificate; a self-insured policy or certificate or a policy or certificate provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health

maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or limited health service benefit plans; and for purposes of KRS 304.17A-600 to 304.17A-633 includes short-term coverage policies;

(7) "Independent review entity" means an individual or organization certified by the ***department***~~[office]~~ to perform external reviews under KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(8) "Insurer" means any of the following entities authorized to issue health benefit plans as defined in subsection (6) of this section: an insurance company, health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association; nonprofit hospital, medical-surgical, or health service corporation; or any other entity authorized to transact health insurance business in Kentucky;

(9) "Internal appeals process" means a formal process, as set forth in KRS 304.17A-617, established and maintained by the insurer, its designee, or agent whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent;

(10) "Nationally recognized accreditation organization" means a private nonprofit entity that sets national utilization review and internal appeal standards and conducts review of insurers, agents, or independent review entities for the purpose of accreditation or certification. Nationally recognized accreditation organizations shall include the National Committee for Quality Assurance (NCQA), the American Accreditation Health Care Commission (URAC), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or any other organization identified by the ***department*** ~~[office]~~;

(11) "Private review agent" or "agent" means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth. "Private review agent" or "agent" does not include an independent review entity which performs external review of adverse determinations;

(12) "Prospective review" means utilization review that is conducted prior to a hospital admission or a course of treatment;

(13) "Provider" shall have the same meaning as set forth in KRS 304.17A-005;

(14) "Qualified personnel" means licensed physician, registered nurse, licensed practical nurse, medical records technician, or other licensed medical personnel who through training and experience shall render consistent decisions based on the review criteria;

(15) "Registration" means an authorization issued by the ***department*** ~~[office]~~ to an insurer or a private review agent to conduct utilization review;

(16) "Retrospective review" means utilization review that is conducted after health care

services have been provided to a covered person. "Retrospective review" does not include the review of a claim that is limited to an evaluation of reimbursement levels, or adjudication of payment;

(17) (a) "Urgent care" means health care or treatment with respect to which the application of the time periods for making nonurgent determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

(b) "Urgent care" shall include all requests for hospitalization and outpatient surgery;

(18) "Utilization review" means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective review; and

(19) "Utilization review plan" means a description of the procedures governing utilization review activities performed by an insurer or a private review agent.

➔Section 1236. KRS 304.17A-607 is amended to read as follows:

(1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the ***department*** ~~[office]~~. A registered insurer or private review agent shall:

(a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;

(b) Ensure that only licensed physicians shall:

1. Make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and

2. Supervise qualified personnel conducting case reviews;

(c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;

(d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264 and 45 C.F.R. secs. 160 to 164 and other applicable laws and administrative regulations;

(e) Provide a toll free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;

(f) Where an insurer, its agent, or private review agent provides or performs utilization review, be available to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays;

(g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse determinations and coverage denials of the insurer or private review agent, in accordance with this section and administrative

regulations promulgated in accordance with KRS 304.17A-609;

(h) Except for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, which shall be considered a concurrent review, provide a utilization review decision relating to urgent and nonurgent care in accordance with 29 C.F.R. Part 2560, including the timeframes and written notice of the decision. A written notice in electronic format, including e-mail or facsimile, may suffice for this purpose where the covered person, authorized person, or provider has agreed in advance in writing to receive such notices electronically and shall include the required elements of subsection (j) of this section;

(i) Provide a utilization review decision within twenty-four (24) hours of receipt of a request for review of a covered person's continued hospital stay and prior to the time when a previous authorization for hospital care will expire;

(j) Provide written notice of review decisions to the covered person, authorized person, and providers. An insurer or agent that denies coverage or reduces payment for a treatment, procedure, drug that requires prior approval, or device shall include in the written notice:

1. A statement of the specific medical and scientific reasons for denial or reduction of payment or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
2. The state of licensure, medical license number, and the title of the reviewer making the decision;
3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
4. Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether the appeal shall be in writing, and any specific filing

procedures, including any applicable time limitations or schedules, and the position and phone number of a contact person who can provide additional information;

(k) Afford participating physicians an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and afford other participating providers an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice; and

(l) Comply with its own policies and procedures on file with the ***department***~~[office]~~ or, if accredited or certified by a nationally recognized accrediting entity, comply with the utilization review standards of that accrediting entity where they are comparable and do not conflict with state law.

(2) The insurer's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be an adverse determination by the insurer for the purpose of initiating an internal appeal as set forth in KRS 304.17A-617. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

(3) An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the ***department***~~[office]~~. No change to policies and procedures shall be effective or used until after it has been filed with and approved by the ***commissioner***~~[executive director]~~.

(4) A private review agent shall provide to the ***department***~~[office]~~ the names of the entities for which the private review agent is performing utilization review in this state. Notice shall be provided within thirty (30) days of any change.

➔Section 1237. KRS 304.17A-609 is amended to read as follows:

The ***department*** ~~[office]~~ shall promulgate emergency administrative regulations regarding utilization review and internal appeal, including the specification of information required of insurers and private review agents which shall, at a minimum, include:

(1) A utilization review plan that contains all information utilized for conducting preadmission, admission, readmission review, preauthorization, continued stay authorization, and retrospective review and which, for each type of review, includes:

(a) Utilization review policies and procedures to evaluate proposed or delivered medical services;

(b) Time frames for review;

(c) A written summary describing the review process and required forms;

(d) Documentation that actively practicing providers with appropriate qualifications are involved in the development or adoption of utilization review criteria relating to specialty and subspecialty areas;

(e) Descriptions and names of review criteria upon which utilization review decisions are based; and

(f) Additional standards, if any, for the consideration of special circumstances;

(2) The type and qualifications of the personnel either employed or under contract to perform utilization review;

(3) Assurance that a toll-free line will be provided that covered persons, authorized persons, and providers may use to contact the insurer or private review agent;

(4) The policies and procedures to ensure that a representative of the insurer or private review agent shall be reasonably accessible to covered persons, authorized persons, and providers at least forty (40) hours per week during normal business hours;

(5) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(6) A copy of the materials designed to inform covered persons, authorized persons,

and providers of the toll-free number and the requirements of the utilization review plan;

(7) A list of the entities for which the private review agent is performing utilization review in this state; and

(8) Evidence of compliance or the ability to comply with the requirements and procedures established regarding utilization review and the administrative regulations promulgated thereunder.

(9) In lieu of disclosing information specified in subsection (1) of this section, an insurer or private review agent may submit to the ***department*** ~~[office]~~ evidence of accreditation or certification, if any, with a nationally recognized accreditation organization that oversees the information described in subsections (1) to (8) of this section, provided that the ***department*** ~~[office]~~ may still require the information in subsection (8) of this section or other information to demonstrate compliance with the requirements of this section and KRS 304.17A-600, 304.17A-607, 304.17A-613, 304.17A-617, 304.17A-623, and 304.17A-625 not covered by the standards of the nationally recognized accreditation organization, as well as basic information necessary for the ***department*** ~~[office]~~ to contact the insurer or private review agent. Nothing in this subsection shall be construed to prohibit or in any way limit the ***department's*** ~~[office's]~~ authority to require the submission of information specified in subsections (1) to (8) of this section or any other information the ***department*** ~~[office]~~ deems necessary for purposes of investigating a complaint that the insurer or private review agent is not in compliance with KRS 304.17A-600 to 304.17A-633.

➔Section 1238. KRS 304.17A-613 is amended to read as follows:

(1) The ***department*** ~~[office]~~ shall, through the promulgation of emergency administrative regulations, develop a process:

(a) For the review of applications for registration of insurers or private review

agents seeking to conduct utilization reviews;

(b) For the review of applications for insurers or private review agents seeking registration renewal to continue as a utilization review entity;

(c) Ensuring that no registration shall be approved unless the ***commissioner***~~[executive director]~~ has documentation or findings that all applicants seeking registration or renewal to conduct utilization review are in compliance with the requirements and procedures established regarding utilization review, and as to renewals, have complied with KRS 304.17A-600 to 304.17A-633 and administrative regulations promulgated to enforce and to administer KRS 304.17A-600 to 304.17A-633; and

(d) Establishing fees for applications and renewals in an amount sufficient to pay the administrative costs of the program and any other costs associated with carrying out the provisions of KRS 304.17A-600, 304.17A-603, 304.17A-605, 304.17A-607, 304.17A-609, 304.17A-611, 304.17A-613, and 304.17A-615.

(2) The registration issued in accordance with this section expires on the second anniversary of the effective date unless it is renewed.

(3) The registration issued under this section is not transferable.

(4) The ***commissioner***~~[executive director]~~ may revoke or suspend the utilization review registration of any insurer or private review agent who does not comply with the requirements and procedures established regarding utilization review or any administrative regulations promulgated thereunder.

(5) The ***department***~~[office]~~ shall establish reporting requirements to:

(a) Evaluate the effectiveness of insurers and private review agents; and

(b) Determine if the utilization review plans are in compliance with the requirements and procedures established regarding utilization review and applicable administrative regulations.

(6) Upon request of any provider, authorized person, or covered person whose care is

subject to review, the ***department***~~[office]~~ shall provide copies of policies or procedures of any insurer or private review agent that has been issued a registration by the ***department***~~[office]~~ to conduct review in this state.

(7) Notwithstanding any provision to the contrary, an insurer or private review agent registered and in good standing under the provisions of KRS 211.461 to 211.466, prior to July 14, 2000, shall be deemed in compliance with requirements and procedures established in KRS 304.17A-600 to 304.17A-633 regarding utilization review and registered accordingly.

(8) Upon receipt of written complaints from covered persons, authorized persons, or providers stating that an insurer or a private review agent has failed to perform a review in accordance with the utilization review plan or the requirements and procedures established regarding utilization review, or administrative regulations promulgated thereunder, the ***commissioner***~~[executive director]~~ shall:

(a) Send a copy of the complaint to the insurer or the private review agent within ten (10) days of receipt of the complaint, and require that any written reply be sent to the ***commissioner***~~[executive director]~~ within ten (10) days; and

(b) Review the complaint and any written reply received from the insurer or private review agent within the time frames set forth in paragraph (a) of this subsection and make a recommendation to the insurer or private review agent and the covered person, authorized person, or provider.

(9) The ***commissioner***~~[executive director]~~ shall consider complaints before issuing or renewing any registration or renewal of a registration to an insurer or a private review agent.

(10) Notwithstanding any provision in this section to the contrary, the ***department***~~[office]~~ shall accept accreditation or certification by a nationally recognized accreditation organization as sufficient documentation or finding for purposes of subsections (1) and (5) of this section that the insurer or private review

agent meets the application requirements for registration or renewal. Insurers or private review agents accredited or certified by a nationally recognized accreditation organization shall be deemed compliant with the utilization review and internal appeals requirements of this section and KRS 304.17A-600, 304.17A-607, 304.17A-609, 304.17A-617, 304.17A-623, and 304.17A-625 and administrative regulations to the extent the standards of such nationally recognized accreditation organization sufficiently meet these requirements. The ***department*** ~~[office]~~ shall have a simplified process in administrative regulations for insurers and private review agents to register using accreditation or certification and shall limit any additional documentation only for demonstrating compliance with requirements in this section and KRS 304.17A-600, 304.17A-607, 304.17A-609, 304.17A-617, 304.17A-623, and 304.17A-625 not met by the standards of a nationally recognized accreditation organization.

➔Section 1239. KRS 304.17A-617 is amended to read as follows:

(1) Every insurer shall have an internal appeal process to be utilized by the insurer or its designee, consistent with this section and KRS 304.17A-619 and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer shall disclose the availability of the internal process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial which meets the requirements set forth in KRS 304.17A-607(1)(j). For purposes of this section, "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan. Where a coverage denial is involved, in addition to stating the reason for the coverage denial, the required notice shall contain instructions for filing a request for internal appeal.

(2) The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person. The internal appeals

process shall include adequate and reasonable procedures for review and resolution of appeals concerning adverse determinations made under utilization review and of coverage denials, including procedures for reviewing appeals from covered persons whose medical conditions require expedited review. At a minimum, these procedures shall include the following:

(a) Insurers or their designees shall provide decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal appeal;

(b) Insurers or their designees shall render a decision not later than three (3) business days after receipt of the request for an expedited appeal of either an adverse determination or a coverage denial. An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part;

(c) Internal appeal of an adverse determination shall only be conducted by a licensed physician who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board eligible or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;

(d) Those portions of the medical record that are relevant to the internal appeal, if

authorized by the covered person and in accordance with state or federal law, shall be considered and providers given the opportunity to present additional information;

(e) In addition to any previous notice required under KRS 304.17A-607(1)(j), and to facilitate expeditious handling of a request for external review of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, or device for a covered person shall provide the covered person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that shall include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
2. The state of licensure, medical license number, and the title of the person making the decision;
3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
4. Instructions for initiating an external review of an adverse determination, or filing a request for review with the ***department*** ~~[office]~~ if a coverage denial is upheld by the insurer on internal appeal.

(3) The ***department*** ~~[office]~~ shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers. For purposes of this subsection, "coverage denials" shall not include an adverse determination as defined in KRS 304.17A-600 or subsequent denials arising from an adverse determination.

(a) On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the ***department*** ~~[office]~~ shall notify the

insurer which issued the denial of the request for review and shall call for the insurer to respond to the ***department*** ~~[office]~~ regarding the request for review within ten (10) business days of receipt of notice to the insurer.

(b) Within ten (10) business days of receiving the notice of the request for review from the ***department*** ~~[office]~~, the insurer shall provide to the ***department*** ~~[office]~~ the following information:

1. Confirmation as to whether the person who received or sought the health service for which coverage was denied was a covered person under a health benefit plan issued by the insurer on the date the service was sought or denied;
2. Confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's appeal process under this section; and
3. The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available.

(c) In addition to the information described in paragraph (b) of this subsection, the insurer and the covered person, authorized person, or provider shall provide to the ***department*** ~~[office]~~ any information requested by the ***department*** ~~[office]~~ that is germane to its review.

(d) On the receipt of the information described in paragraphs (b) and (c) of this subsection, unless the ***department*** ~~[office]~~ is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of the covered person's health benefit plan. If the ***department*** ~~[office]~~ determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the

insurer shall either cover the service, or afford the covered person an opportunity for external review under KRS 304.17A-621, 304.17A-623, and 304.17A-625, where the conditions precedent to the review are present. If the ***department*** ~~[office]~~ notifies the insurer that the treatment, service, drug, or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review.

(e) An insurer shall be required to cover the treatment, service, drug, or device that was denied or provide notification of the right to external review in accordance with paragraph (d) of this subsection whether the covered person has disenrolled or remains enrolled with the insurer.

(f) If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was denied for a period not to exceed thirty (30) days, or provide the covered person the opportunity for external review.

➔Section 1240. KRS 304.17A-621 is amended to read as follows:

The Independent External Review Program is hereby established in the ***department*** ~~[office]~~. The program shall provide covered persons with a formal, independent review to address disagreements between the covered person and the covered person's insurer regarding an adverse determination made by the insurer, its designee, or a private review agent. This section and KRS 304.17A-623 and 304.17A-625 establish requirements and procedures governing external review and independent review entities.

➔Section 1241. KRS 304.17A-623 is amended to read as follows:

(1) Every insurer shall have an external review process to be utilized by the insurer or its designee, consistent with this section and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer, its designee, or agent shall disclose the availability of the external review process to the covered

person in the insured's timely notice of an adverse determination or notice of a coverage denial as set forth in KRS 304.17A-607(1)(j) and in the denial letter required in KRS 304.17A-617(1) and (2)(e). For purposes of this section "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.

(2) A covered person, an authorized person, or a provider acting on behalf of and with the consent of the covered person, may request an external review of an adverse determination rendered by an insurer, its designee, or agent.

(3) The insurer shall provide for an external review of an adverse determination if the following criteria are met:

(a) The insurer, its designee, or agent has rendered an adverse determination;

(b) The covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2). The insurer and the covered person may however, jointly agree to waive the internal appeal requirement;

(c) The covered person was enrolled in the health benefit plan on the date of service or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested; and

(d) The entire course of treatment or service will cost the covered person at least one hundred dollars ($100) if the covered person had no insurance.

(4) The covered person, an authorized person, or a provider with consent of the covered person shall submit a request for external review to the insurer within sixty (60) days, except as set forth in KRS 304.17A-619(1), of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process. As part of the request, the covered person shall provide to the insurer or its designee written consent authorizing the independent review entity to obtain all necessary

medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

(5) The covered person shall be assessed a one (1) time filing fee of twenty-five dollars ($25) to be paid to the independent review entity and which may be waived if the independent review entity determines that the fee creates a financial hardship on the covered person. The fee shall be refunded if the independent review entity finds in favor of the covered person.

(6) A covered person shall not be afforded an external review of an adverse determination if:

(a) The subject of the covered person's adverse determination has previously gone through the external review process and the independent review entity found in favor of the insurer; and

(b) No relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.

(7) The ***department*** ~~[office]~~ shall establish a system for each insurer to be assigned an independent review entity for external reviews. The system established by the ***department*** ~~[office]~~ shall be prospective and shall require insurers to utilize independent review entities on a rotating basis so that an insurer does not have the same independent review entity for two (2) consecutive external reviews. The ***department*** ~~[office]~~ shall contract with no less than two (2) independent review entities.

(8) (a) If a dispute arises between an insurer and a covered person regarding the covered person's right to an external review, the covered person may file a complaint with the ***department*** ~~[office]~~. Within five (5) days of receipt of the complaint, the ***department*** ~~[office]~~ shall render a decision and may direct the insurer to submit the dispute to an independent review entity for an external review if it finds:

1. The dispute involves denial of coverage based on medical necessity or the service being experimental or investigational; and
2. All of the requirements of subsection (3) of this section have been met.

(b) The complaint process established in this section shall be separate and distinct from, and shall in no way limit other grievance or complaint processes available to consumers under other provisions of the KRS or duly promulgated administrative regulations. This complaint process shall not limit, alter, or supplant the mechanisms for appealing coverage denials established in KRS 304.17A-617.

(9) The external review process shall be confidential and shall not be subject to KRS 61.805 to 61.850 and KRS 61.870 to 61.884.

(10) External reviews shall be conducted in an expedited manner by the independent review entity if the covered person is hospitalized, or if, in the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of a bodily organ or part.

(11) Requests for expedited external review, shall be forwarded by the insurer to the independent review entity within twenty-four (24) hours of receipt by the insurer.

(12) For expedited external review, a determination shall be made by the independent review entity within twenty-four (24) hours from the receipt of all information required from the insurer. An extension of up to twenty-four (24) hours may be allowed if the covered person and the insurer or its designee agree. The insurer or its designee shall provide notice to the independent review entity and to the covered person, by same-day communication, that the adverse determination has been

assigned to an independent review entity for expedited review.

(13) External reviews which are not expedited shall be conducted by the independent review entity and a determination made within twenty-one (21) calendar days from the receipt of all information required from the insurer. An extension of up to fourteen (14) calendar days may be allowed if the covered person and the insurer are in agreement.

➔Section 1242. KRS 304.17A-625 is amended to read as follows:

(1) In making its decision, an independent review entity conducting the external review shall take into account all of the following:

(a) Information submitted by the insurer, the covered person, the authorized person, and the covered person's provider, including the following:

1. The covered person's medical records;

2. The standards, criteria, and clinical rationale used by the insurer to make its decision; and

3. The insurer's health benefit plan;

(b) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health, or any board recognized by the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, and the United States Food and Drug Administration, the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services, and the Agency for Health Care Research and Quality; and

(c) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical specialists, and clinical guidelines adopted by relevant national medical societies.

(2) The independent review entity shall base its decision on the information submitted under subsection (1) of this section. In making its decision, the independent review

entity shall consider safety, appropriateness, and cost effectiveness.

(3) The insurer shall provide any coverage determined by the independent review entity to be medically necessary. The independent review entity shall not be permitted to allow coverage for services specifically limited or excluded by the insurer in its health benefit plan. The decision shall apply only to the individual covered person's external review.

(4) Nothing in this section shall be construed as requiring an insurer to provide coverage for out of network services, procedures, or tests, except as set forth in KRS 304.17A-515(1)(c) and 304.17A-550.

(5) The insurer shall be responsible for the cost of the external review.

(6) The independent review entity shall provide to the covered person, treating provider, insurer, and the ***department*** ~~[office]~~ a decision which shall include:

(a) The findings for either the insurer or covered person regarding each issue under review;

(b) The proposed service, treatment, drug, device, or supply for which the review was performed;

(c) The relevant provisions in the insurer's health benefit plan and how applied; and

(d) The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

(7) The decision of the independent review entity shall not be made solely for the convenience of the insurer, the covered person, or the provider.

(8) Consistent with the rules of evidence, a written decision prepared by an independent review entity shall be admissible in any civil action related to the adverse determination. The independent review entity's decision shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

(9) The decision of the independent review entity shall be binding on the insurer with respect to that covered person. Failure of the insurer to provide coverage as required by the independent review entity shall:

(a) Be a violation of the insurance code of a nature sufficient to warrant the ***commissioner***~~[executive director]~~ revoking or suspending the insurer's license or certificate of authority; and

(b) Constitute an unfair claims settlement practice as set forth in KRS 304.12-230.

(10) Failure to provide coverage as required by the independent review entity shall also subject the insurer to the provisions of KRS 304.99-010 and 304.99-020 and require the insurer to pay the claim that was the subject of the external review, without need for the covered person or authorized person to further establish a right as to the payment amount. Reasonable attorney fees associated with the actions of the insured necessary to collect amounts owed the covered person shall be assessed against and borne by the insurer.

(11) The insurer shall implement the decision of the independent review entity whether the covered person has disenrolled or remains enrolled with the insurer.

(12) If the covered person has been disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was previously denied by the insurer, its agent, or designee and later approved by the independent review entity for a period not to exceed thirty (30) days.

(13) Within thirty (30) days of the decision in favor of the covered person by the independent review entity, the insurer shall provide written notification to the ***department***~~[office]~~ that the decision has been implemented in accordance with this section.

(14) An independent review entity and any medical specialist the entity utilizes in conducting an external review shall not be liable in damages in a civil action for

injury, death, or loss to person or property and is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review. This subsection does not grant immunity from civil liability or professional disciplinary action to an independent review entity or medical specialist for an action that is outside the scope of authority granted in KRS 304.17A-621, 304.17A-623, and 304.17A-625.

(15) Nothing in KRS 304.17A-600 to 304.17A-633 shall be construed to create a cause of action against any of the following:

(a) An employer that provides health care benefits to employees through a health benefit plan;

(b) A medical expert, private review agent, or independent review entity that participates in the utilization review, internal appeal, or external review addressed in KRS 304.17A-600 to 304.17A-633; or

(c) An insurer or provider acting in good faith and in accordance with any finding, conclusion, or determination of an Independent Review Entity acting within the scope of authority set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625.

(16) The covered person, insurer, or provider in the external review may submit written complaints to the ***department*** ~~[office]~~ regarding any independent review entity's actions believed to be an inappropriate application of the requirements set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625. The ***department*** ~~[office]~~ shall promptly review the complaint, and if the ***department*** ~~[office]~~ determines that the actions of the independent review entity were inappropriate, the ***department*** ~~[office]~~ shall take corrective measures, including decertification or suspension of the independent review entity from further participation in external reviews. The ***department's*** ~~[office's]~~ actions shall be subject to the powers and administrative procedures set forth in subtitle 17A of KRS Chapter 304.

➔Section 1243. KRS 304.17A-627 is amended to read as follows:

(1) To be certified as an independent review entity under this chapter, an organization shall submit to the ***department*** ~~[office]~~ an application on a form required by the ***department*** ~~[office]~~. The application shall include the following:

(a) The name of each stockholder or owner of more than five percent (5%) of any stock or options for an applicant;

(b) The name of any holder of bonds or notes of the applicant that exceeds one hundred thousand dollars ($100,000);

(c) The name and type of business of each corporation or other organization that the applicant controls or with which it is affiliated and the nature and extent of the affiliation or control;

(d) The name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under paragraph (c) of this subsection and a description of any relationship the named individual has with an insurer as defined in KRS 304.17A-600 or a provider of health care services;

(e) The percentage of the applicant's revenues that are anticipated to be derived from independent reviews;

(f) A description of the minimum qualifications employed by the independent review entity to select health care professionals to perform external review, their areas of expertise, and the medical credentials of the health care professionals currently available to perform external reviews; and

(g) The procedures to be used by the independent review entity in making review determinations.

(2) If at any time there is a material change in the information included in the application, provided for in subsection (1) of this section, the independent review entity shall submit updated information to the ***department*** ~~[office]~~.

(3) An independent review entity shall not be a subsidiary of, or in any way affiliated

with, or owned, or controlled by an insurer or a trade or professional association of payors.

(4) An independent review entity shall not be a subsidiary of, or in any way affiliated with, or owned, or controlled by a trade or professional association of providers.

(5) Health care professionals who are acting as reviewers for the independent review entity shall hold in good standing a nonrestricted license in a state of the United States.

(6) Health care professionals who are acting as reviewers for the independent review entity shall hold a current certification by a recognized American medical specialty board or other recognized health care professional boards in the area appropriate to the subject of the review, be a specialist in the treatment of the covered person's medical condition under review, and have actual clinical experience in that medical condition.

(7) The independent review entity shall have a quality assurance mechanism to ensure the timeliness and quality of the review, the qualifications and independence of the physician reviewer, and the confidentiality of medical records and review material.

(8) Neither the independent review entity nor any reviewers of the entity, shall have any material, professional, familial, or financial conflict of interest with any of the following:

(a) The insurer involved in the review;

(b) Any officer, director, or management employee of the insurer;

(c) The provider proposing the service or treatment or any associated independent practice association;

(d) The institution at which the service or treatment would be provided;

(e) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the covered person whose treatment is under review; or

(f) The covered person.

(9) As used in this section, "conflict of interest" shall not be interpreted to include:

(a) A contract under which an academic medical center or other similar medical center provides health care services to covered persons, except for academic medical centers that may provide the service under review;

(b) Provider affiliations which are limited to staff privileges; or

(c) A specialist reviewer's relationship with an insurer as a contracting health care provider, except for a specialist reviewer proposing to provide the service under review.

(10) On an annual basis, the independent review entity shall report to the ***department*** ~~[office]~~ the following information:

(a) The number of independent review decisions in favor of covered persons;

(b) The number of independent review decisions in favor of insurers;

(c) The average turnaround time for an independent review decision;

(d) The number of cases in which the independent review entity did not reach a decision in the time specified in statute or administrative regulation; and

(e) The reasons for any delay.

➔Section 1244. KRS 304.17A-629 is amended to read as follows:

The ***commissioner*** ~~[executive director]~~ shall promulgate administrative regulations to implement the provisions of KRS 304.17A-621, 304.17A-623, 304.17A-625, 304.17A-627, 304.17A-629, and 304.17A-631.

➔Section 1245. KRS 304.17A-633 is amended to read as follows:

The ***commissioner*** ~~[executive director]~~ shall report every six (6) months to the Interim Joint Committee on Banking and Insurance, and to the Governor on the state of the Independent External Review Program. The report shall include a summary of the number of reviews conducted, medical specialties affected, and a summary of the findings and recommendations made by the independent external review entity.

➔Section 1246. KRS 304.17A-649 is amended to read as follows:

The ***commissioner***~~[executive director]~~ shall promulgate administrative regulations necessary to implement the provisions of KRS 304.17A-640, 304.17A-641, 304.17A-643, 304.17A-645, and 304.17A-647.

➔Section 1247. KRS 304.17A-665 is amended to read as follows:

Sixty (60) days prior to the regular session of the General Assembly in 2002, and sixty (60) days prior to each subsequent even-numbered-year regular session of the General Assembly, the ***commissioner***~~[executive director]~~ shall submit a written report to the Legislative Research Commission on the impact on health insurance costs of KRS 304.17A-660 to 304.17A-669.

➔Section 1248. KRS 304.17A-700 is amended to read as follows:

As used in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123:

(1) "Adjudicate" means an insurer pays, contests, or denies a clean claim;

(2) "Claims payment time frame" means the time period prescribed under KRS 304.17A-702 following receipt of a clean claim from a provider at the address published by the insurer, whether it is the address of the insurer or a delegated claims processor, within which an insurer is required to pay, contest, or deny a health care claim;

(3) "Clean claim" means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:

(a) A clean claim from an institutional provider shall consist of:

1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;

2. Entries stated as mandatory by the NUBC; and

3. Any state-designated data requirements determined and approved by the

Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

(b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.

(c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.

(d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

(4) "***Commissioner***~~[Executive director]~~" means the ***commissioner***~~[executive director]~~ of the ***Department***~~[Office]~~ of Insurance;

(5) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services;

(6) "***Department***~~[Office]~~" means the ***Department***~~[Office]~~ of Insurance;

(7) "Electronic" or "electronically" means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;

(8) "Health benefit plan" has the same meaning as provided in KRS 304.17A-005;

(9) "Health care provider" or "provider" means a provider licensed in Kentucky as defined in KRS 304.17A-005 and, for the purposes of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 only, shall include physical therapists licensed under KRS Chapter 327, psychologists licensed under KRS Chapter 319, and social workers licensed under KRS Chapter 335. Nothing contained in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall be construed to include physical therapists, psychologists, and social workers as a health care provider or provider under KRS 304.17A-005;

(10) "Health claim attachments" means medical information from a covered person's

medical record required by the insurer containing medical information relating to the diagnosis, the treatment, or services rendered to the covered person and as may be required pursuant to KRS 304.17A-720;

(11) "Institutional provider" means a health care facility licensed under KRS Chapter 216B;

(12) "Insurer" has the same meaning provided in KRS 304.17A-005;

(13) "Kentucky Uniform Billing Committee (KUBC)" means the committee of health care providers, governmental payors, and commercial insurers established as a local arm of NUBC to implement the bill requirements of the NUBC and to prescribe any additional billing requirements unique to Kentucky insurers;

(14) "National Uniform Billing Committee (NUBC)" means the national committee of health care providers, governmental payors, and commercial insurers that develops the national uniform billing requirements for institutional providers as referenced in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, sec. 300gg et seq.;

(15) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person; and

(16) "Utilization review" has the same meaning as provided in KRS 304.17A-600(18).

➔Section 1249. KRS 304.17A-720 is amended to read as follows:

(1) In order to improve the efficiency and effectiveness of the health care system through administrative simplification of billing requirements, the ***commissioner***~~[executive director]~~ shall prescribe, through the promulgation of administrative regulations, standardized health claim attachments to be used by all insurers requiring additional medical information to process health care claims. The Kentucky State Uniform Billing Committee shall make recommendations to the ***commissioner***~~[executive director]~~ on the standardization of attachments.

(2) Any administrative regulations that prescribe standardized health claim attachments

shall be updated to conform with federal standards following the release of national requirements for transactions and data elements in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, sec. 300gg et seq.

➔Section 1250. KRS 304.17A-722 is amended to read as follows:

(1) No later than ninety (90) days following July 15, 2002, the ***department*** ~~[office]~~ shall promulgate administrative regulations requiring all insurers to report information on a calendar quarter basis on prompt payment of claims to providers, as defined in KRS 304.17A-700, that shall be limited to the following:

(a) The number of clean claims received by the insurer, its agent, or designee during the reporting period;

(b) The percentage of clean claims received by the insurer, its agent, or designee that were:

1. Adjudicated within the claims payment timeframe;
2. Adjudicated within one (1) to thirty (30) days from the end of the claims payment timeframe;
3. Adjudicated within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe;
4. Adjudicated within sixty-one (61) to ninety (90) days from the end of the claims payment timeframe;
5. Adjudicated more than ninety (90) days from the end of the claims payment timeframe; and
6. Not yet adjudicated;

(c) The percentage of clean claims received during the reporting quarter that were paid and not denied or contested:

1. Within the claims payment timeframe;
2. Within one (1) to thirty (30) days from the end of the claims payment

timeframe;

3. Within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe;

4. Within sixty (60) to ninety (90) days from the end of the claims payment timeframe;

5. More than ninety (90) days from the end of the claims payment timeframe; and

6. Not yet paid;

(d) Amount of interest paid; and

(e) For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment timeframe.

(2) Data required in subsection (1) of this section shall be reported for hospitals, physicians, and all other providers, excluding pharmacies.

(3) Insurers shall submit information required in subsection (1) of this section to the ***department*** ~~[office]~~ no later than one hundred eighty (180) days following the close of the reporting quarter.

(4) The ***department*** ~~[office]~~ shall, as part of the market conduct survey of each insurer, audit the insurer to determine compliance with KRS 304.17A-700 to 304.17A-730 and KRS 304.14-135 and 304.99-123. Findings shall be made available to the public upon request.

(5) The ***commissioner*** ~~[executive director]~~ shall annually present to the Interim Joint Committee on Banking and Insurance and to the Governor a report on the payment practices of insurers and compliance with the provisions of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 and the ***commissioner's*** ~~[executive director's]~~ enforcement activities, including the number of complaints received and those acted upon by the ***department*** ~~[office]~~.

➔Section 1251. KRS 304.17A-752 is amended to read as follows:

(1) No individual or business entity shall act or hold themselves out as an insurance purchasing outlet without first being registered as an insurance purchasing outlet by the ***commissioner***~~[executive director]~~ of the Kentucky ***Department***~~[Office]~~ of Insurance in accordance with KRS 304.17A-750 to 304.17A-770 and 304.47-020.

(2) No individual or business entity shall act for an insurance purchasing outlet to sell, solicit, or negotiate a health benefit plan to an eligible person unless the individual or business entity acting for the insurance purchasing outlet is licensed in accordance with Subtitle 9 of Chapter 304 as an agent with a health line of authority.

(3) The ***commissioner***~~[executive director]~~ may promulgate administrative regulations necessary to administer KRS 304.17A-750 to 304.17A-770 and 304.47-020.

➔Section 1252. KRS 304.17A-754 is amended to read as follows:

(1) A business entity seeking to obtain a certificate of registration to act as an insurance purchasing outlet shall complete and file with the ***commissioner***~~[executive director]~~ of the Kentucky ***Department***~~[Office]~~ of Insurance an application prescribed by the ***commissioner***~~[executive director]~~.

(2) An application shall not be deemed filed until all information necessary to process the application properly has been received by the ***commissioner***~~[executive director]~~.

(3) Within one hundred eighty (180) days of receipt of an application for a certificate of registration, the ***commissioner***~~[executive director]~~ shall make a determination concerning the application and provide notice to the applicant. If approved, a certificate of registration, in a form prescribed by the ***commissioner***~~[executive director]~~, shall be provided to the insurance purchasing outlet.

(4) The business entity seeking a certificate of registration to act as an insurance purchasing outlet shall file the following with the ***commissioner***~~[executive director]~~:

(a) Organizational information, including partnership agreements, articles of incorporation, bylaws, and other applicable documents;

(b) A business plan, including plan of operations, marketing plan, and financial projections of not less than three (3) years;

(c) Appeal procedures for denied enrollment to a health purchasing outlet;

(d) Enrollment procedures;

(e) Payment procedures;

(f) Evidence of financial responsibility to operate as an insurance purchasing outlet in the form of the following:

1. A fidelity bond in an amount not less than ten percent (10%) of projected annual premiums collected; and

2. A certificate of an insurer authorized to write legal liability insurance in Kentucky certifying that the insurer has and will keep in effect on behalf of the insurance purchasing outlet a policy of insurance covering the legal liability of the insurance purchasing outlet as a result of erroneous acts or failure to act in its capacity as an insurance purchasing outlet. The policy shall provide indemnification for the benefit of any aggrieved party as a result of each single occurrence in the sum of not less than ten thousand dollars ($10,000). The policy shall not be terminated unless at least thirty (30) days prior written notice has been given to the ***commissioner***~~[executive director]~~ and to the insurance purchasing outlet;

(g) Biographical affidavits of owners, partners, officers, and directors of the applicant;

(h) Identification of any contracted company which manages the insurance purchasing outlet, or any administrator which adjusts or settles claims of the insurance purchasing outlet members;

(i) Names and addresses of the principal places of business of the applicants;

(j) Geographic area to be serviced;

(k) Requirements for membership and participation in the insurance purchasing outlet;

(l) Name and address of each participating insurer, if known;

(m) Proposed health benefit plan to be offered, if known; and

(n) Any other information required by the ***commissioner***~~[executive director]~~ to evaluate the applicant's suitability as an insurance purchasing outlet.

(5) Any information filed by an insurance purchasing outlet pursuant to subsection (4) of this section that changes shall be refiled with the ***commissioner***~~[executive director]~~ for approval.

(6) The ***commissioner***~~[executive director]~~ may promulgate administrative regulations to establish standards in accordance with subsection (4) of this section.

➔Section 1253. KRS 304.17A-758 is amended to read as follows:

(1) The insurance purchasing outlet may collect premiums and the value of vouchers from or on behalf of insurance purchasing outlet members under its administrator license.

(2) The insurance purchasing outlet shall not adjust or settle claims on insurance purchasing outlet members under its administrator license.

(3) The insurance purchasing outlet shall comply with KRS 304.9-371 to 304.9-377.

(4) The insurance purchasing outlet shall furnish annual and quarterly financial statements no later than sixty (60) days after the end of the reporting period on a form prescribed by the ***commissioner***~~[executive director]~~. Additionally, the insurance purchasing outlet shall furnish to the ***commissioner***~~[executive director]~~ annual audited financial statements based on generally accepted accounting principles by an independent certified public accountant on or before one hundred twenty (120) days from the end of the insurance purchasing outlet's fiscal year for

the immediately preceding fiscal year.

(5) The books and records of the insurance purchasing outlet shall be retained in the state of Kentucky and made available to the ***commissioner*** ~~[executive director]~~ for inspection or examination.

(6) Upon payment of all applicable fees, the certificate of registration issued in accordance with KRS 304.17A-754 shall be renewed at the same time that the insurance purchasing outlet renews its administrator license in accordance with Subtitle 9 of Chapter 304.

(7) The certificate of registration issued under KRS 304.17A-754 is not transferable.

(8) The ***department*** ~~[office]~~ shall promulgate administrative regulations to establish fees for the initial registration and renewal of registration of an insurance purchasing outlet.

➔Section 1254. KRS 304.17A-760 is amended to read as follows:

(1) An insurance purchasing outlet shall:

(a) Set and collect fees to finance necessary costs incurred in marketing, selling, servicing, and administering its services;

(b) Offer health benefit plans to eligible persons;

(c) Provide premium and voucher collection services for participating insurers;

(d) Establish and adhere to appropriate administrative and accounting procedures for operating the health purchasing outlet;

(e) Establish and adhere to rules, conditions, and procedures for insurance purchasing outlet members and participating insurers;

(f) Establish and adhere to enrollment and participation requirements for insurance purchasing outlet members;

(g) Receive, review, and conduct appeals for persons who have been denied enrollment to an insurance purchasing outlet;

(h) Demonstrate and maintain at all times proof of financial responsibility and

solvency;

(i) Prepare an annual report on the operations of the insurance purchasing outlet in accordance with administrative regulations promulgated by the ***commissioner***~~[executive director]~~;

(j) Establish procedures for billing and collection of premiums from insurance purchasing outlet members;

(k) Establish procedures for collecting and redeeming vouchers; and

(l) Maintain an administrator license in accordance with Subtitle 9 of Chapter 304.

(2) An insurance purchasing outlet may:

(a) Contract with qualified third parties for any services necessary to carry out the powers and duties authorized or required by this chapter;

(b) Employ necessary staff;

(c) Sue or be sued;

(d) Contract with independent licensed administrators to adjust or settle claims, since the insurance purchasing outlet is prohibited from these activities in accordance with KRS 304.17A-758; and

(e) Employ, contract, or otherwise use licensed insurance agents to market and service coverage.

➔Section 1255. KRS 304.17A-762 is amended to read as follows:

(1) For administrative purposes, an insurance purchasing outlet shall be the policyholder or contract holder of the health benefit plan on behalf of an insurance purchasing outlet member.

(2) The participating insurer shall issue a certificate of coverage to each insurance purchasing outlet member.

(3) The insurance purchasing outlet shall provide the following disclosures to an insurance purchasing outlet member at the time of enrollment:

(a) The insurance purchasing outlet is not an insurer and does not pay benefits or claims. It collects and distributes premiums on behalf of insurance purchasing outlet members;

(b) The insurance purchasing outlet is registered with the Kentucky ***Department***~~[Office]~~ of Insurance to provide specific administrative services and may not assume any risk for claim and benefit payments; and

(c) Other disclosures as the ***commissioner***~~[executive director]~~ shall require by administrative regulation.

➔Section 1256. KRS 304.17A-768 is amended to read as follows:

(1) A voucher issued by an employer shall only be redeemable at an insurance purchasing outlet. A voucher shall be nonassignable and nontransferable.

(2) An insurance purchasing outlet shall redeem the value of the voucher with the employer. If an employer fails to redeem the value of the voucher, the insurance purchasing outlet shall notify the eligible person. An eligible person may pay the premium amount directly to the insurance purchasing outlet if the employer fails to redeem the value of the voucher.

(3) An insurance purchasing outlet shall pay an insurer the appropriate premium amount on or before the premium due date. If an insurance purchasing outlet fails to pay the premium amount on or before the due date the following shall occur:

(a) An insurer shall issue the insurance purchasing outlet a notice of termination if the premium amount is not paid pursuant to KRS 304.17A-245.

(b) Upon receipt of a notice of termination from the insurer, the insurance purchasing outlet shall issue the eligible member a notice of termination.

(c) The insurer shall notify the eligible person of his ***or her*** conversion rights under KRS 304.18-110.

(4) An insurer may allow for a thirty-one (31) day grace period for the premium amount to be paid by the insurance purchasing outlet.

(5) The ***department***~~[office]~~ shall prescribe the items to be included on a voucher.

(6) An insurance purchasing outlet shall be required to accept a voucher as payment for a health benefit plan, or as partial payment if the value of the voucher is insufficient to cover the full premium of the health benefit plan.

(7) An insurance purchasing outlet may charge a reasonable administrative fee to cover the cost of processing the voucher.

(8) The ***commissioner***~~[executive director]~~ shall promulgate administrative regulations to implement the provisions of this section.

➔Section 1257. KRS 304.17A-802 is amended to read as follows:

(1) "Administrator" means an individual, partnership, corporation, association, or other legal entity engaged by a self-insured employer-organized association group's board of trustees to carry out the policies established by the group's board of trustees and to provide day-to-day management of the group.

(2) "Agent" means any person directly or indirectly associated with such organization who engages in solicitation or enrollment of persons for profit or pecuniary gain in a self-insured employer-organized association group.

(3) "***Commissioner***~~[Executive director]~~" means the ***commissioner***~~[executive director]~~ of the ***Department***~~[Office]~~ of Insurance.

(4) "Deceptive" means an act, practice, or statement which has the tendency or capacity to deceive, without regard to whether there is an intent to deceive or whether any person has suffered loss or injury as a result of the act, practice, or statement.

(5) "Employer-organized association" means an entity defined in KRS 304.17A-804.

(6) "Governmental entity" means the Commonwealth of Kentucky, other states, or the United States, their political subdivisions, municipal corporations, or public agencies.

(7) "Insolvent" or "insolvency" means the inability of a self-insured employer-organized association group to pay its outstanding lawful obligations as they mature

in the regular course of business, as may be shown either by an excess of its required reserves and other liabilities over its assets or by its not having sufficient assets to reinsure all of its outstanding liabilities after paying all accrued claims owed by it.

(8) "Person" includes but is not limited to any individual, partnership, association, trust, or corporation.

(9) "Qualified actuary" means a member of the American Academy of Actuaries or a Fellow of the Society of Actuaries.

(10) "Self-insured employer-organized association group" means a group described in KRS 304.17A-804.

(11) "Service company" means a person or entity which provides services not provided by the administrator, including but not limited to claims adjustment, compilation of statistics in preparation of contribution and assessments, loss, and tax reports, preparation of other required self-insurance reports, development of members' contributions, assessments, and fees, and administration of a claim fund.

(12) "Unfair" means an act, practice, or statement which is unconscionable.

➔Section 1258. KRS 304.17A-806 is amended to read as follows:

No person or entity in this state shall be, act as, or hold itself out as a self-insured employer-organized association group unless it holds a certificate of filing from the ***commissioner***~~[executive director]~~. All certificates of filing shall be issued by the ***commissioner***~~[executive director]~~.

➔Section 1259. KRS 304.17A-808 is amended to read as follows:

A proposed self-insured employer-organized association group shall file with the ***commissioner***~~[executive director]~~ an application for a certificate of filing accompanied by a nonrefundable filing fee of five dollars ($5). Each application for a certificate of filing shall be submitted to the ***commissioner***~~[executive director]~~ upon a form prescribed by the ***commissioner***~~[executive director]~~ and shall set forth or be accompanied by:

(1) The group's name, location of its principal office, date of organization, and identification of its fiscal year. The application shall also include the name and address of each member if known at the time of application. If this information is unknown, a description of the group to be solicited for membership shall be included;

(2) A copy of the articles of association or governance documents;

(3) A copy of agreements with the administrator and with any service company;

(4) A copy of the bylaws of the proposed group;

(5) Certification of the group's financial solvency as set forth in KRS 304.17A-812;

(6) Designation of the initial board of trustees and administrator;

(7) The address where books and records of the group will be maintained at all times; and

(8) A statement describing the self-insured employer-organized association which shall include:

(a) The health services to be offered;

(b) The financial risks to be assumed;

(c) The initial geographic area to be served;

(d) Pro forma financial projections for the first three (3) years of operation, including the assumptions the projections are based upon;

(e) The sources of working capital and funding;

(f) A description of the persons to be covered by the self-insured employer-organized association;

(g) Any proposed reinsurance arrangements;

(h) Any proposed management, administrative, or cost-sharing arrangements; and

(i) A description of the self-insured employer-organized association's proposed method of marketing.

➔Section 1260. KRS 304.17A-810 is amended to read as follows:

Upon receipt of an application for a certificate of filing, the ***commissioner***~~[executive director]~~ shall issue or deny the same. A certificate of filing shall be issued only if the ***commissioner***~~[executive director]~~ finds that the applicant has complied with KRS 304.17A-808, has paid the application fee, and the ***commissioner***~~[executive director]~~ is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the self-insured employer-organized association group are competent, trustworthy, and possess good reputation;

(2) The self-insured employer-organized association group is financially responsible and may reasonably be expected to meet its obligations to participants and prospective participants. In making this determination, the ***commissioner***~~[executive director]~~ may consider:

(a) The adequacy of working capital;

(b) Any agreement with an insurer, a government, or any other organization for insuring the payment of health claims or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the self-insurance group; and

(c) Compliance with KRS 304.17A-812, as a guarantee that the obligations will be duly performed.

➔Section 1261. KRS 304.17A-812 is amended to read as follows:

(1) This section applies to a group applying for and holding a certificate of filing as a self-insured employer-organized association group.

(2) To obtain and to maintain its certificate of filing, a self-insured employer-organized association group shall have sufficient financial strength to pay all public or professional liabilities covered by the group, including known claims and expenses and incurred but unreported claims and expenses.

(3) The ***commissioner***~~[executive director]~~ shall require the following of a self-insured

employer-organized association group:

(a) An actuarial certification by a member of the American Academy of Actuaries of the adequacy of the proposed rates funding arrangements of the group;

(b) Specific reinsurance ensuring the solvency of the funding arrangement;

(c) A demonstration of capital and surplus as follows:

1. Initial financial requirements. Every self-insured employer-organized association shall demonstrate initial capital and surplus equal to the greater of:

a. Five hundred thousand dollars ($500,000);

b. Two percent (2%) of projected annual contribution revenues on the first one hundred fifty million dollars ($150,000,000) of contributions and one percent (1%) of projected annual contributions on the contributions in excess of one hundred fifty million dollars ($150,000,000); or

c. An amount equal to the sum of eight percent (8%) of projected annual health care expenditures except those paid on a capitated basis or managed hospital payment basis and four percent (4%) of projected annual hospital expenditures paid on a managed hospital payment basis.

2. Continuing financial requirements. Every self-insured employer-organized association shall demonstrate ongoing capital and surplus equal to the greater of:

a. Five hundred thousand dollars ($500,000);

b. Two percent (2%) of annual contribution revenues, as reported on the most recent annual financial statement filed with the ***commissioner***~~[executive director]~~, on the first one hundred fifty million dollars ($150,000,000) of contributions and one percent

(1%) of annual premiums on the contributions in excess of one hundred fifty million dollars ($150,000,000); or

c. An amount equal to the sum of eight percent (8%) of projected annual health care expenditures except those paid on a capitated basis or managed hospital payment basis and four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis, as reported on the most recent financial statement filed with the ***commissioner*** ~~[executive director]~~; and

(d) A fidelity bond for the administrator and a fidelity bond for the service company in forms and amounts prescribed by the ***commissioner*** ~~[executive director]~~.

(4) The ***commissioner*** ~~[executive director]~~, if not satisfied with the financial strength of a self-insured employer-organized association group, may require any or all of the following of a self-insured employer-organized association group:

(a) Security in the form and amount prescribed by the ***commissioner*** ~~[executive director]~~ as follows:

1. A surety bond issued by a corporate surety authorized to transact business in the Commonwealth of Kentucky; or

2. Any financial security endorsement issued as part of an acceptable excess insurance contract issued by an authorized insurer, which may be used to meet all or part of the security requirement.

The bond or financial security endorsement shall be solely for the benefit of the insured creditors to pay claims and associated expenses and shall be payable upon the failure of the group to pay professional or public liability claims the group is legally obligated to pay. The ***commissioner*** ~~[executive director]~~ may establish and adjust the requirements for the amount of security based on differences among groups in their size, types of business, years in

existence, or other relevant factors.

(b) Specific and aggregate excess insurance in a form and amount issued by an insurer acceptable to the ***commissioner***~~[executive director]~~.

➔Section 1262. KRS 304.17A-814 is amended to read as follows:

A self-insured employer-organized association group shall notify the ***commissioner***~~[executive director]~~ immediately of any change in the information required to be filed under KRS 304.17A-808 or 304.17A-812.

➔Section 1263. KRS 304.17A-816 is amended to read as follows:

The funds of a self-insured employer-organized association group shall be invested only in securities or other investments permitted by Subtitle 7 of this chapter, or such other securities or investments as the ***commissioner***~~[executive director]~~ may permit by administrative regulation.

➔Section 1264. KRS 304.17A-820 is amended to read as follows:

The ***commissioner***~~[executive director]~~ or any person authorized by him ***or her*** shall have the power to examine the financial condition, affairs, and management of any self-insured employer-organized association group subject to the provisions of KRS 304.17A-800 to 304.17A-844. The ***commissioner***~~[executive director]~~ shall have free access to all the books, papers, and documents relating to the business of the organization, and may summon witnesses and administer oaths and affirmations in the examination of the directors, trustees, officers, agents, representatives, or employees of any group, or any person in relation to its affairs, transactions, or conditions. The ***commissioner***~~[executive director]~~ shall so examine each self-insured employer-organized association group subject to the provisions of KRS 304.17A-800 to 304.17A-844 no less frequently than every four (4) years. An examination under this section shall be subject to the provisions of KRS 304.2-210 to 304.2-290.

➔Section 1265. KRS 304.17A-824 is amended to read as follows:

(1) A certificate of filing remains in effect until terminated at the request of the group

or suspended or revoked by the ***commissioner*** ~~executive director~~ pursuant to KRS 304.17A-840.

(2) The ***commissioner*** ~~executive director~~ shall not grant the request of the self-insured employer-organized association group to terminate its certificate of filing unless the group has filed with the ***commissioner*** ~~executive director~~ a statement describing what arrangements, if any, have been made to pay obligations of the group, including both known claims and expenses and incurred but unreported claims and expenses.

(3) Subject to filing with the ***commissioner*** ~~executive director~~, a self-insured employer-organized association group may merge with another self-insured employer-organized association group. As a result of any merger, the resulting self-insured employer-organized association shall assume in full all obligations of the constituent groups.

➔Section 1266. KRS 304.17A-826 is amended to read as follows:

(1) Each group shall be operated by a board of trustees which shall consist of not less than two (2) persons selected in the manner prescribed by the self-insured employer-organized association or by other laws of the Commonwealth. The trustees shall not be officers, employees, or agents of an administrator or servicing organization. All trustees shall be residents of Kentucky or officers of corporations authorized to do business in Kentucky. The trustees shall have the authority to administer the operations of the self-insured employer-organized association group, and to assure that there is adequate funding to cover health liabilities, that all claims are paid promptly, and that all necessary precautions are taken to safeguard the assets of the group.

(2) The board of trustees shall:

(a) Maintain responsibility for all moneys collected or disbursed from the group;

(b) Maintain minutes of its meetings and make the minutes available to the

commissioner~~[executive director]~~; and

(c) Designate an administrator to carry out the policies established by the board of trustees and to provide day-to-day management of the group, and delineate in the written minutes of its meetings the areas of authority it delegates to the administrator.

(3) The board of trustees shall not:

(a) Extend credit to individual group members for payment of contributions or assessments, except pursuant to payment plans filed with the ***commissioner***~~[executive director]~~; or

(b) Permit the loan of any moneys to, or borrow any moneys from, the group or in the name of the group.

(4) In its discretion, the self-insured employer-organized association group may refer to its trustees as directors. If this is done, the provisions of KRS 304.17A-800 to 304.17A-844 referring to trustees shall be construed as referring to directors.

➔Section 1267. KRS 304.17A-832 is amended to read as follows:

(1) All self-insured employer-organized association groups shall file with the ***commissioner***~~[executive director]~~ a statement of financial condition audited by an independent certified public accountant on or before one hundred twenty (120) days from the end of the group's fiscal year for the immediately preceding fiscal year. The financial statement shall be in a form approved by the ***commissioner***~~[executive director]~~ and shall include:

(a) Actuarially-appropriate reserves for:

1. Known claims and expenses associated therewith.

2. Claims incurred but not reported and any expenses associated therewith.

3. Unearned contributions and assessments.

4. Bad debts, which reserves shall be known as liabilities.

(b) An actuarial opinion by a qualified actuary and a supporting reserve study

regarding reserves for known claims and expenses associated therewith. The reserve study shall include documentation sufficient for another actuary practicing in the same field to evaluate the work. The documentation shall describe clearly the sources of data, material assumptions, and methods.

(2) No person shall make a deceptive statement or fail to correct a misstatement in connection with the solicitation of membership of a group.

(3) The financial statements required by this section shall be completed in accordance with administrative regulations promulgated by the ***commissioner***~~[executive director]~~.

➔Section 1268. KRS 304.17A-834 is amended to read as follows:

Self-insured employer-organized association groups shall file with the ***commissioner***~~[executive director]~~ their rates, underwriting guidelines, evidence of coverage, and any changes therein. The filing shall be accompanied by a filing fee of five dollars ($5) per form filing.

➔Section 1269. KRS 304.17A-840 is amended to read as follows:

(1) The ***commissioner***~~[executive director]~~ may suspend or revoke any certificate of filing issued to a self-insured employer-organized association group if the ***commissioner***~~[executive director]~~ finds that any of the following conditions exist:

(a) The self-insured employer-organized association group is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under KRS 304.17A-800 to 304.17A-844, unless amendments to the submissions have been filed with and approved by the ***commissioner***~~[executive director]~~;

(b) The self-insured employer-organized association group is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to participants or prospective participants;

(c) The self-insured employer-organized association group, or any person at its direction, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(d) The self-insured employer-organized association group has engaged in any unfair or deceptive practices under its certificate of filing; or

(e) The self-insured employer-organized association group has failed to correct a violation of KRS 304.17A-800 to 304.17A-844 or the administrative regulations promulgated thereunder, within a reasonable time period established by the ***commissioner***~~[executive director]~~ in administrative regulations.

(2) A certificate of filing shall be suspended or revoked only after compliance with the hearing procedure set forth in KRS 304.2-310 to 304.2-370.

(3) When a certificate of filing of a self-insured employer-organized association group is suspended, the group shall not, during the period of suspension, enroll any new participants and shall not engage in any advertising or solicitation.

(4) If the certificate of filing of a self-insured employer-organized association group is revoked, the group shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business, except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation. The ***commissioner***~~[executive director]~~ may, by written order, prevent further operation of the group if he ***or she*** finds it to be in the best interest of the participants, to the end that the participants will be afforded the greatest practical opportunity to obtain health coverage elsewhere. If the ***commissioner***~~[executive director]~~ permits further operation, the self-insured employer-organized association group shall continue to collect the contributions required of participants.

➔Section 1270. KRS 304.17A-842 is amended to read as follows:

The ***commissioner***~~[executive director]~~ may promulgate reasonable administrative regulations not inconsistent with the provisions of KRS 304.17A-800 to 304.17A-844 that he ***or she*** deems necessary for the proper administration of these sections. Nothing in KRS 304.17A-800 to 304.17A-844 or 304.17A-320 or any administrative regulation promulgated thereunder shall require any self-insured employer-organized association group or its members to take any action in violation of the Constitution of the Commonwealth of Kentucky.

➔Section 1271. KRS 304.17A-844 is amended to read as follows:

(1) After a hearing or upon agreement by the self-insured employer-organized association group, the ***commissioner***~~[executive director]~~ may suspend or revoke the certificate of filing of a self-insured employer-organized association group, impose a civil penalty of up to five thousand dollars ($5,000) per violation on a self-insured employer-organized association group, or both, for:

(a) Violations of KRS 304.17A-800 to 304.17A-844 or administrative regulations promulgated thereunder;

(b) Obtaining a certificate of filing by unfair or deceptive means;

(c) Operating in a financially hazardous manner;

(d) Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand any moneys that belong to a member, an employee of a member, or a person otherwise entitled thereto by the group or its administrator; or

(e) Unfair or deceptive business practices.

(2) The ***commissioner***~~[executive director]~~, in his ***or her*** discretion and without advance notice or a hearing thereon, may suspend or revoke the certificate of filing of any self-insured employer-organized association group upon the commencement of the following proceedings:

(a) Receivership;

(b) Conservatorship;

(c) Rehabilitation; or

(d) Other delinquency proceedings.

➔Section 1272. KRS 304.17A-846 is amended to read as follows:

(1) Any insurer issuing or delivering group health benefit plans in the Commonwealth shall provide to an employer-organized association health benefit plan, within thirty (30) calendar days after a written request, the information relating to its health benefit plan that has been requested, including but not limited to the following information for the previous three (3) years or for the entire period of coverage, whichever is shorter:

(a) Aggregate claims experience by month, including claims experience for pharmacy benefits;

(b) Total premiums paid by month;

(c) Total number of insureds on a monthly basis by coverage tier; and

(d) Sufficient detailed claims information to permit the employer-organized association to verify eligibility and participation of the groups and individuals participating in the employer-organized association program.

The ***department***~~[office]~~ shall, by July 15, 2005, promulgate administrative regulations to implement the provisions of this section and define the extent that individual information shall be provided.

(2) This section shall not require the insurer to disclose any nonpublic personal health information without the written consent of the individual who is the subject of the information, as required by administrative regulations promulgated by the ***commissioner***~~[executive director]~~. However, nonpublic personal health information may be provided to the employer-organized association health benefit plan and large group health benefit plan with fifty-one (51) or more enrolled employees as a covered entity to cover entity transfer under the Federal Health Insurance Portability

and Accountability Act of 1996 (HIPAA), 42 U.S.C. sec. 300gg et seq., provided that the health benefit plan certifies to the insurer that it has adopted HIPAA-required safeguards and will treat the nonpublic personal health information in accordance with HIPAA standards.

(3) Any insurer issuing or delivering group health benefit plans in the Commonwealth shall provide to a large group health benefit plan with fifty-one (51) or more enrolled employees, within thirty (30) calendar days after receipt of a written request, the following information relating to its health benefit plan:

(a) Total premiums paid by month;

(b) Total number of insureds on a monthly basis by coverage tier; and

(c) Additional utilization data to help the employer measure costs in the following areas:

1. Detailed prescription drug utilization information, including generic versus brand utilization;

2. Number of office visits to primary care providers and specialists;

3. Number of emergency room visits;

4. Number of inpatient and outpatient hospitalizations;

5. Number of members utilizing deductible and out-of-pocket expenses by cost level; and

6. A list of the most prevalent disease categories.

(4) Insurers shall not be required to produce reports requested pursuant to subsection (3) of this section more than twice annually.

➔Section 1273. KRS 304.17B-001 is amended to read as follows:

As used in this subtitle, unless the context requires otherwise:

(1) "Administrator" is defined in KRS 304.9-051(1);

(2) "Agent" is defined in KRS 304.9-020;

(3) "Assessment process" means the process of assessing and allocating guaranteed

acceptance program losses or Kentucky Access funding as provided for in KRS 304.17B-021;

(4) "Authority" means the Kentucky Health Care Improvement Authority;

(5) "Case management" means a process for identifying an enrollee with specific health care needs and interacting with the enrollee and their respective health care providers in order to facilitate the development and implementation of a plan that efficiently uses health care resources to achieve optimum health outcome;

(6) "***Commissioner***~~[Executive director]~~" is defined in KRS 304.1-050(1);

(7) "***Department***~~[Office]~~" is defined in KRS 304.1-050(2);

(8) "Earned premium" means the portion of premium paid by an insured that has been allocated to the insurer's loss experience, expenses, and profit year to date;

(9) "Enrollee" means a person who is enrolled in a health benefit plan offered under Kentucky Access;

(10) "Eligible individual" is defined in KRS 304.17A-005(11);

(11) "Guaranteed acceptance program" or "GAP" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(12) "Guaranteed acceptance program participating insurer" means an insurer that offered health benefit plans through December 31, 2000, in the individual market to guaranteed acceptance program qualified individuals;

(13) "Health benefit plan" is defined in KRS 304.17A-005(22);

(14) "High-cost condition" means acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open-heart surgery, Parkinson's disease, polycystic kidney, psychotic

disorders, quadriplegia, stroke, syringomyelia, Wilson's disease, chronic renal failure, malignant neoplasm of the trachea, malignant neoplasm of the bronchus, malignant neoplasm of the lung, malignant neoplasm of the colon, short gestation period for a newborn child, and low birth weight of a newborn child;

(15) "Incurred losses" means for Kentucky Access the excess of claims paid over premiums received;

(16) "Insurer" is defined in KRS 304.17A-005(27);

(17) "Kentucky Access" means the program established in accordance with KRS 304.17B-001 to 304.17B-031;

(18) "Kentucky Access Fund" means the fund established in KRS 304.17B-021;

(19) "Kentucky Health Care Improvement Authority" means the board established to administer the program initiatives listed in KRS 304.17B-003(5);

(20) "Kentucky Health Care Improvement Fund" means the fund established for receipt of the Kentucky tobacco master settlement moneys for program initiatives listed in KRS 304.17B-003(5);

(21) "MARS" means the Management Administrative Reporting System administered by the Commonwealth;

(22) "Medicaid" means coverage in accordance with Title XIX of the Social Security Act, 42 U.S.C. secs. 1396 et seq., as amended;

(23) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. secs. 1395 et seq., as amended;

(24) "Pre-existing condition exclusion" is defined in KRS 304.17A-220(6);

(25) "Standard health benefit plan" means a health benefit plan that meets the requirements of KRS 304.17A-250;

(26) "Stop-loss carrier" means any person providing stop-loss health insurance coverage;

(27) "Supporting insurer" means all insurers, stop-loss carriers, and self-insured employer-controlled or bona fide associations; and

(28) "Utilization management" is defined in KRS 304.17A-500(12).

➔Section 1274. KRS 304.17B-003 is amended to read as follows:

(1) There is hereby established the Kentucky Health Care Improvement Authority as an agency, instrumentality, and political subdivision of the Commonwealth and a public body corporate and politic with all the powers, duties, and responsibilities conferred upon it by statute and necessary or convenient to carry out its functions. The authority shall be administered by a board of fifteen (15) members and is created to perform the public functions of administering programs financed by the funds appropriated to the authority in conformance with KRS 304.17B-001 to 304.17B-031 and any terms and conditions established by the General Assembly as a part of the act appropriating the funds. The members of the board shall consist of the following:

(a) The ***commissioner***~~[executive director]~~ of the ***Department***~~[Office]~~ of Insurance, or the ***commissioner's***~~[executive director's]~~ designated representative, who shall serve as chair;

(b) The secretary of the Cabinet for Health and Family Services, or the secretary's designated representative, who shall serve as vice chair;

(c) Two (2) nonvoting members serving ex officio from the House of Representatives, one (1) of whom shall be appointed by the Speaker of the House and one (1) appointed by the minority floor leader, and who shall serve a term of two (2) years;

(d) Two (2) nonvoting members serving ex officio from the Senate, one (1) of whom shall be appointed by the President of the Senate and one (1) appointed by the minority floor leader, and who shall serve a term of two (2) years;

(e) The deans of the University of Louisville School of Medicine and the University of Kentucky College of Medicine, or their designated representatives;

(f) The commissioner of the Department for Public Health, or the commissioner's designated representative;

(g) Two (2) representatives of Kentucky health care providers, who shall be appointed by the Governor; and

(h) Four (4) citizens at large of the Commonwealth, who shall be appointed by the Governor.

(2) The terms of office of the initial appointments of the citizen at-large members of the board shall expire one (1), two (2), three (3), and four (4) years respectively from the expiration date of the initial appointment. One (1) of the initial terms of the representatives of health care providers, at least one (1) of whom shall be male and at least one (1) of whom shall be female, shall be for two (2) years and one (1) shall be for four (4) years. All succeeding appointments shall be for four (4) years from the expiration date of the term of the initial appointment. Two (2) of the citizens at large shall be male and two (2) shall be female. Board members shall serve until their successors are appointed.

(3) In making private sector and citizen-at-large appointments to the board, the Governor shall assure broad geographical and ethnic representation as well as representation from consumers and the major sectors of Kentucky's health care and health insurance businesses. Private sector and citizen-at-large members shall serve without compensation but shall be reimbursed for reasonable and necessary expenses.

(4) The authority shall establish procedures for accountability, including the review of expenditures, and develop mechanisms to measure the success of programs that receive allocated funds in accordance with any criteria or instructions provided by the General Assembly. The authority shall be attached to the ***Department*** ~~[Office]~~ of Insurance for administrative purposes and shall establish advisory boards it deems appropriate, which shall consist of health insurance consumers, health care

providers, and insurance company representatives, to assist with oversight of fund expenditures.

(5) Grants and funds obtained under KRS 304.17B-001 to 304.17B-031 shall be used for expenditures as follows:

(a) Seventy percent (70%) of all moneys in the fund shall be placed into the Kentucky Access fund for the purpose of funding Kentucky Access;

(b) Twenty percent (20%) of all moneys in the fund shall be spent on a collaborative partnership between the University of Louisville and the University of Kentucky dedicated to lung cancer research; and

(c) Ten percent (10%) of all moneys in the fund shall be used to discourage the use of harmful substances by minors.

(6) The authority shall assure that a public hearing is held on the expenditure of funds allocated under this section, except for funds allocated to the Kentucky Access fund. Advertisement of the public hearing shall be published at least once but may be published two (2) more times, if one (1) publication occurs not less than seven (7) days nor more than twenty-one (21) days before the scheduled date of the public hearing. The authority shall submit an annual report to the Governor and the General Assembly indicating how the funds were used and an evaluation of the program's effectiveness in health care and access to health insurance for Kentucky residents.

(7) Neither the authority nor its employees shall be liable for any obligations of any of the programs established under KRS 304.17B-001 to 304.17B-031. No member or employee of the authority shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under KRS 304.17B-001 to 304.17B-031, unless the act or omission constitutes willful or wanton misconduct. The authority may provide in its policies and procedures for indemnification of, and legal representation for, its

members and employees.

(8) The authority shall have all the powers necessary or convenient to carry out and effectuate the purposes and provisions of KRS 304.17B-001 to 304.17B-031, including, but not limited to, retaining the staff it deems necessary for the proper performance of its duties.

(9) The authority shall meet at least quarterly and at other times upon call of the chair or a majority of the authority.

➔Section 1275. KRS 304.17B-005 is amended to read as follows:

(1) There is hereby created Kentucky Access, which shall ensure that health coverage is made available to each Kentucky individual resident applying and qualifying for coverage. Any health coverage provided under this section shall begin no sooner than January 1, 2001. Kentucky Access is designed for the purpose of implementing an acceptable alternative mechanism within the meaning of 42 U.S.C. sec. 300gg-44(a)(1) so that Kentucky may preserve the flexibility over the regulation of health coverage allowed by federal law.

(2) Kentucky Access shall operate under the Division of Kentucky Access in the ***Department***~~[Office]~~ of Insurance. The division shall be headed by a division director appointed by the secretary of the ~~[Environmental and]~~Public Protection Cabinet in accordance with KRS 12.050.

(3) Neither the ***department***~~[office]~~ nor its employees shall be liable for any obligations of Kentucky Access. No member or employee of the ***department***~~[office]~~ shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under KRS 304.17B-001 to 304.17B-031, unless such act or omission constitutes willful or wanton misconduct. The ***department***~~[office]~~ may provide in its policies and procedures for indemnification of, and legal representation for, its members and employees.

➔Section 1276. KRS 304.17B-007 is amended to read as follows:

In its duties to operate and administer Kentucky Access, the ***department***~~[office]~~ shall, through itself or designated agents:

(1) Establish administrative and accounting procedures for the operation of Kentucky Access;

(2) Enter into contracts as necessary;

(3) Take legal action necessary:

(a) To avoid the payment of improper claims against Kentucky Access or the coverage provided by or through Kentucky Access;

(b) To recover any amounts erroneously or improperly paid by Kentucky Access;

(c) To recover any amounts paid by the Kentucky Access as a result of mistake of fact or law;

(d) To recover other amounts due Kentucky Access; or

(e) To operate and administer its obligations under the provisions of KRS 304.17B-001 to 304.17B-031;

(4) Establish, and modify as appropriate, rates, rate schedules, rate adjustments, premium rates, expense allowances, claim reserve formulas, and any other actuarial function appropriate to the administration and operation of Kentucky Access. Premium rates and rate schedules may be adjusted for appropriate factors, including, but not limited to, age and sex, and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

(5) Establish procedures under which applicants and participants in Kentucky Access shall have an internal grievance process and a mechanism for external review through an independent review organization in accordance with this chapter;

(6) Select a third-party administrator in accordance with KRS 304.17B-011;

(7) Require that all health benefit plans, riders, endorsements, or other forms and documents used to administer Kentucky Access meet the requirements of Subtitles

12, 14, 17, 17A, and 38 of this chapter;

(8) Adopt nationally recognized uniform claim forms in accordance with this chapter;

(9) Develop and implement a marketing strategy to publicize the existence of Kentucky Access, including, but not limited to, eligibility requirements, procedures for enrollment, premium rates, and a toll–free telephone number to call for questions;

(10) Establish and review annually provider reimbursement rates that ensure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under Kentucky Access at least to the extent that such care and services are available to the general population. The ***department*** ~~[office]~~ shall only authorize contracts with health care providers that prohibit the provider from collecting from the enrollee any amounts in excess of copayment amounts, coinsurance amounts, deductible amounts, and amounts for noncovered services;

(11) Conduct periodic audits to assure the general accuracy of the financial and claims data submitted to the ***department*** ~~[office]~~ and be subject to an annual audit of its operations;

(12) Issue health benefit plans January 1, 2001, or thereafter, in accordance with the requirements of KRS 304.17B-001 to 304.17B-031;

(13) Require a referral fee of fifty dollars ($50) to be paid to agents who refer applicants who are subsequently enrolled in Kentucky Access. The referral fee shall be paid only on the initial enrollment of an applicant. Referral fees shall not be paid on any enrollments of enrollees who have been previously enrolled in Kentucky Access, or for renewals for enrollees;

(14) Bill and collect premiums from enrollees in the amount determined by the ***department*** ~~[office]~~;

(15) Assess insurers and stop-loss carriers in accordance with KRS 304.17B-021;

(16) Reimburse GAP participating insurers for GAP losses pursuant to KRS 304.17B-

021;

(17) Establish a provider network for Kentucky Access by developing a statewide provider network or by contracting with an insurer for a statewide provider network. In the event the ***department***~~[office]~~ contracts with an insurer, the ***department***~~[office]~~ may take into consideration factors including, but not limited to, the size of the provider network, the composition of the provider network, and the current market rate of the provider network. The provider network shall be made available to the third-party administrator specified in KRS 304.17B-011 and shall be limited to Kentucky Access enrollees.

(18) Be audited by the Auditor of Public Accounts;

(19) By administrative regulation, amend the definition of high-cost conditions provided in KRS 304.17B-001 by adding other high-cost conditions;

(20) The ***department***~~[office]~~ shall report on an annual basis to the Interim Joint Committee on Banking and Insurance the separation plan pursuant to KRS 304.17A-080 for the division of duties and responsibilities between the operation of the ***Department***~~[Office]~~ of Insurance and the operation of Kentucky Access; and

(21) Any other actions as may be necessary and proper for the execution of the ***department's***~~[office's]~~ powers, duties, and obligations under KRS 304.17B-001 to 304.17B-031.

➔Section 1277. KRS 304.17B-009 is amended to read as follows:

In its duties to operate and administer Kentucky Access, the ***department***~~[office]~~ may, through itself or third parties:

(1) Exercise any and all powers granted to insurers under this chapter; and

(2) Sue or be sued.

➔Section 1278. KRS 304.17B-011 is amended to read as follows:

(1) The ***department***~~[office]~~ shall select a third-party administrator, through the state competitive bidding process, to administer Kentucky Access. The third-party

administrator shall be an administrator licensed by the ***department*** ~~[office]~~. The ***department*** ~~[office]~~ shall consider criteria in selecting a third-party administrator that shall include, but not be limited to, the following:

(a) A third-party administrator's proven ability to demonstrate performance of the operations of an insurer to include the following: enrollee enrollment, eligibility determination, provider enrollment and credentialing, utilization management, quality improvement, drug utilization review, premium billing and collection, claims payment, and data reporting;

(b) The total cost to administer Kentucky Access;

(c) A third-party administrator's proven ability to demonstrate that Kentucky Access shall be administered in a cost-efficient manner;

(d) A third-party administrator's proven ability to demonstrate experience in two (2) or more states administering a risk pool for a minimum of a three (3) year period; and

(e) A third-party administrator's financial condition and stability.

(2) The ***department*** ~~[office]~~ may contract with the third-party administrator for a period of four (4) years with an option for a two (2) year extension as approved by the ***department*** ~~[office]~~ on a year-by-year contract basis. At least one (1) year prior to the expiration of the third-party administrator's contract, the ***department*** ~~[office]~~ may solicit third-party administrators, including the current third-party administrator, to submit bids to serve as the third-party administrator for the succeeding four (4) year period.

(3) In addition to any duties and obligations set forth in the contract with the third-party administrator, the third-party administrator shall:

(a) Develop and establish policies and procedures for enrollee enrollment, eligibility determination, provider enrollment and credentialing, utilization management, case management, disease management, quality improvement,

drug utilization review, premium billing and collection, data reporting, and other responsibilities determined by the ***department*** ~~[office]~~;

(b) Develop and establish policies and procedures for paying the agent referral fee under KRS 304.17B-001 to 304.17B-031;

(c) Develop and establish policies and procedures to ensure timely and efficient payment of claims to include, but not limited to, the following:

1. Develop and provide a claims billing manual to health care providers enrolled in Kentucky Access that includes information relating to the proper billing of a claim and the types of claim forms to use;
2. Payment of all claims in accordance with the provisions of this chapter and the administrative regulations promulgated thereunder; and
3. Notification to an enrollee through an explanation of benefits if a claim is denied or if there is enrollee financial responsibility of a paid claim for deductible or coinsurance amounts;

(d) Issue denial letters under KRS 304.17A-540 for denial of preauthorization and precertification requests for medical necessity and medical appropriateness determinations;

(e) Submit information to the ***department*** ~~[office]~~ under KRS 304.17A-330;

(f) Submit reports to the ***department*** ~~[office]~~ regarding the operation and financial condition of Kentucky Access. The frequency, content, and form of the reports shall be determined by the ***department*** ~~[office]~~;

(g) Submit an annual report to the ***department*** ~~[office]~~ three (3) months after the end of each calendar year. The annual report shall include:

1. Earned premium;
2. Administrative expenses;
3. Incurred losses for the year;
4. Paid losses for the year;

5. Number of enrollees enrolled in Kentucky Access by category of eligibility; and

6. Any other information requested by the ***department*** ~~[office]~~; and

(h) Be subject to examination by the ***department*** ~~[office]~~ under Subtitles 2 and 3 of this chapter.

(4) The third-party administrator shall be paid for necessary and reasonable expenses, as provided in the contract between the ***department*** ~~[office]~~ and the third-party administrator.

➔Section 1279. KRS 304.17B-013 is amended to read as follows:

(1) The schedule of rates, premium rates charged to enrollees, deductible amounts, copayment amounts, coinsurance amounts, and other cost-sharing amounts shall be established by the ***department*** ~~[office]~~. Premium rates charged to enrollees are not intended to fully cover the cost of providing health care coverage to Kentucky Access enrollees, and any claims in excess of premium rates shall be covered by the Kentucky Access fund.

(2) Premium rates for health benefit plans provided under Kentucky Access shall bear a reasonable relationship to each other. Premium rates shall be varied based on age and gender. The initial premium rates for plan coverage shall not exceed one hundred fifty percent (150%) of the applicable individual standard risk rates, as established by the ***department*** ~~[office]~~. In no event shall premium rates exceed one hundred seventy-five percent (175%) of the rates applicable to individual standard risks.

(3) Premium rates for coverage issued by Kentucky Access shall be established annually by the ***department*** ~~[office]~~, using reasonable actuarial principles, and shall reflect anticipated experience and expenses for risks under Kentucky Access.

➔Section 1280. KRS 304.17B-015 is amended to read as follows:

(1) Any individual who is an eligible individual is eligible for coverage under Kentucky

Access, except as specified in paragraphs (a), (b), (d), and (e) of subsection (4) of this section.

(2) Any individual who is not an eligible individual who has been a resident of the Commonwealth for at least twelve (12) months immediately preceding the application for Kentucky Access coverage is eligible for coverage under Kentucky Access if one (1) of the following conditions is met:

(a) The individual has been rejected by at least one (1) insurer for coverage of a health benefit plan that is substantially similar to Kentucky Access coverage;

(b) The individual has been offered coverage substantially similar to Kentucky Access coverage at a premium rate greater than the Kentucky Access premium rate at the time of enrollment or upon renewal; or

(c) The individual has a high-cost condition listed in KRS 304.17B-001.

(3) A Kentucky Access enrollee whose premium rates exceed claims for a three (3) year period shall be issued a notice of insurability. The notice shall indicate that the Kentucky Access enrollee has not had claims exceed premium rates for a three (3) year period and may be used by the enrollee to obtain insurance in the regular individual market.

(4) An individual shall not be eligible for coverage under Kentucky Access if:

(a) The individual has, or is eligible for, on the effective date of coverage under Kentucky Access, substantially similar coverage under another contract or policy, unless the individual was issued coverage from a GAP participating insurer as a GAP qualified individual prior to January 1, 2001. A GAP qualified individual shall be automatically eligible for coverage under Kentucky Access without regard to the requirements of subsection (2) of this section. An individual who is ineligible for coverage pursuant to this paragraph shall not preclude the individual's spouse or dependents from being eligible for Kentucky Access coverage. As used in this paragraph, "eligible

for" includes any individual who was eligible for coverage but waived that coverage. That individual shall be ineligible for Kentucky Access coverage through the period of waived coverage;

(b) The individual is eligible for coverage under Medicaid or Medicare;

(c) The individual previously terminated Kentucky Access coverage and twelve (12) months have not elapsed since the coverage was terminated, unless the individual demonstrates a good faith reason for the termination;

(d) Except for covered benefits paid under the standard health benefit plan as specified in KRS 304.17B-019, Kentucky Access has paid two million dollars ($2,000,000) in covered benefits per individual. The maximum limit under this paragraph may be increased by the ***department*** ~~[office]~~; or

(e) The individual is confined to a public institution or incarcerated in a federal, state, or local penal institution or in the custody of federal, state, or local law enforcement authorities, including work release programs.

(5) The coverage of any person who ceases to meet the requirements of this section or the requirements of any administrative regulation promulgated under this subtitle may be terminated.

➔Section 1281. KRS 304.17B-017 is amended to read as follows:

(1) At least annually, the ***department*** ~~[office]~~ shall evaluate and revise as necessary rates to be charged to Kentucky Access enrollees.

(2) Except as provided in KRS 304.17B-019, the ***department*** ~~[office]~~ may revise its health benefit plans, cost-sharing arrangements, plan delivery rules, schedule of benefits, rates, and cost-containment features provided under Kentucky Access at the time of the health benefit plan renewal as necessary to ensure that Kentucky Access maintains adequate resources for continued operation.

➔Section 1282. KRS 304.17B-019 is amended to read as follows:

(1) Kentucky Access shall offer at least three (3) health benefit plans to enrollees,

which shall be similar to the health benefit plans currently being marketed to individuals in the individual market. One (1) plan shall be the standard health benefit plan set forth in KRS 304.17A-250.

(2) At least one (1) plan shall be offered in a traditional fee-for-service form. At least one (1) plan may be offered in a managed-care form at such time as the ***department*** ~~[office]~~ can establish an appropriate provider network in available service areas.

(3) The ***department*** ~~[office]~~ shall provide for utilization review and case management for all health benefit plans issued under Kentucky Access.

(4) The ***department*** ~~[office]~~ shall review and compare health benefit plans provided under Kentucky Access to health benefit plans provided in the individual market. Based on the review, the ***department*** ~~[office]~~ may amend or replace the health benefit plans issued under Kentucky Access, except for the standard health benefit plan as specified in subsection (1) of this section.

(5) Individuals who apply and are determined eligible for health benefit plans issued under Kentucky Access shall have coverage effective the first day of the month after the application month.

(6) For eligible individuals, health benefit plans issued under Kentucky Access shall not impose any pre-existing condition exclusions. In all other cases, a pre-existing condition exclusion may be imposed in accordance with KRS 304.17A-230.

(7) Health benefit plans issued under Kentucky Access shall be guaranteed renewable except as otherwise specified in KRS 304.17B-015 and KRS 304.17A-240.

(8) All health benefit plans issued under Kentucky Access shall provide that, upon the death or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty-three (63) days to continue under the same or a different contract.

(9) Health benefit plans issued under Kentucky Access shall coordinate benefits with

other health benefit plans and be the payor of last resort.

(10) Except for the standard health benefit plan specified in subsection (1) of this section, health benefit plans issued under Kentucky Access shall pay covered benefits up to a lifetime limit of two million dollars ($2,000,000) per covered individual. The maximum limit under this subsection may be increased by the ***department*** ~~[office]~~.

➔Section 1283. KRS 304.17B-021 is amended to read as follows:

(1) In addition to the other powers enumerated in KRS 304.17B-001 to 304.17B-031, the ***department*** ~~[office]~~ shall assess insurers in the amounts specified in this section. The assessment shall be used for the purpose of funding GAP losses and Kentucky Access.

(a) The amount of the assessment for each calendar year shall be as follows:

1. From each stop-loss carrier, an amount that is equal to two dollars ($2) upon each one hundred dollars ($100) of health insurance stop-loss premiums;

2. From all insurers, an amount based on the total amount of all health benefit plan premiums earned during the prior assessment period and paid by all insurers who received any of the health benefit plan premiums on which the annual assessment is based. The percentage rate used for the annual assessment shall be the same percentage rate as calculated in the GAP risk adjustment process for the six (6) month period of July 1, 1998, through December 31, 1998;

3. If determined necessary by the ***department*** ~~[office]~~, a second assessment may be assessed in the same manner as the annual assessment in subparagraph 2. of this paragraph; and

4. In no event shall the sum of the first assessment provided for in subparagraph 2. of this paragraph and the second assessment provided

for in subparagraph 3. of this paragraph be greater than one percent (1%) of the total amount of all assessable health benefit plan premiums earned during the prior assessment period.

(b) The first assessment shall be for the period from January 1, 2000, through December 31, 2000, and shall be paid on or before March 31, 2001. Subsequent annual assessments shall be paid on or before March 31 of the year following the assessment period.

(2) Every supporting insurer shall report to the ***department*** ~~[office]~~, in a form and at the time as the ***department*** ~~[office]~~ may specify, the following information for the specified period:

(a) The insurer's total stop-loss premiums and health benefit plan premiums in the individual, small group, large group, and association markets; and

(b) Other information as the ***department*** ~~[office]~~ may require.

(3) As part of the assessment process, the ***department*** ~~[office]~~ shall establish and maintain the Kentucky Access fund. All funds shall be held at interest, in a single depository designated in accordance with KRS 304.8-090(1) under a written trust agreement in accordance with KRS 304.8-095. All expense and revenue transactions of the fund shall be posted to the Management Administrative Reporting System (MARS) and its successors.

(4) The Kentucky Access fund shall be funded from the following sources:

(a) Premiums paid by Kentucky Access enrollees;

(b) The funds designated for Kentucky Access in the Kentucky Health Care Improvement fund;

(c) Appropriations from the General Assembly;

(d) All premium taxes collected under KRS Chapter 136 from any insurer, and any retaliatory taxes collected under KRS 304.3-270 from any insurer, for accident and health premiums that are in excess of the amount of the premium

taxes and retaliatory taxes collected for the calendar year 1997;

(e) Annual assessments from supporting insurers;

(f) A second assessment from supporting insurers;

(g) Gifts, grants, or other voluntary contributions;

(h) Interest or other earnings on the investment of the moneys held in the account; and

(i) Any funds remaining on January 1, 2001, in the guaranteed acceptance program account may be transferred to the Kentucky Access fund.

(5) The ***department*** ~~[office]~~ shall determine on behalf of Kentucky Access the premiums, the expenses for administration, the incurred losses, taking into account investment income and other amounts needed to satisfy reserves, estimated claim liabilities, and other obligations for each calendar year. The ***department*** ~~[office]~~ shall also determine the amount of the actual guaranteed acceptance program plan losses for each calendar year. The ***department*** ~~[office]~~ shall assess insurers as follows:

(a) On or before March 31 of each year, the amount set forth in subsection (1)(a)1. and (1)(a)2. of this section.

(b) If the amount of actual guaranteed acceptance program plan losses exceeds the assessment provided for in paragraph (a) of this subsection, a second assessment shall be authorized under subsection (1)(a)3. of this section. If the amount of GAP losses exceeds the assessments provided under subsection (1)(a)1., subsection (1)(a)2., and subsection (1)(a)3. of this section, moneys received and available from the Kentucky Health Care Improvement Fund after the ***department*** ~~[office]~~ determines available funding for Kentucky Access for the current calendar year pursuant to subsection (6) of this section, shall be used to reimburse GAP participating insurers for any actual guaranteed acceptance program losses. If the amount of GAP losses exceeds

the amount in the Kentucky Health Care Improvement Fund after reserving sufficient funds for Kentucky Access for the current year, each GAP participating insurer shall be reimbursed up to the amount of its proportional share of actual guaranteed acceptance program plan losses from the fund. Effective for any assessment on or after January 1, 2001, in calculating GAP losses, total premiums and total claims of the GAP participating insurer shall be used. Actual guaranteed acceptance program losses shall be calculated as the difference between the total GAP claims and the total GAP premiums on an aggregate basis.

(c) If GAP losses are fully covered by the assessment process provided for in subsection (1)(a)1. and (1)(a)2. of this section and the second assessment provided for in subsection (1)(a)3. of this section is not necessary to cover GAP losses, and as determined by the ***department*** ~~[office]~~ using reasonable actuarial principles Kentucky Access funding is needed, a second assessment provided for in subsection (1)(a)3. of this section shall be completed.

(6) After the end of each calendar year, GAP losses shall be reimbursed only after the ***department*** ~~[office]~~ determines that appropriate funding is available for Kentucky Access for the current calendar year. GAP losses shall be reimbursed after reserving sufficient funds for Kentucky Access.

(7) With respect to a GAP participating insurer who reasonably will be expected both to pay assessments and to receive payments from the assessment fund, the ***department*** ~~[office]~~ shall calculate the net amount owed to or to be received from the fund, and the ***department*** ~~[office]~~ shall only collect assessments for or make payments from the fund based upon net amounts.

(8) Insurers paying an assessment may include in any health insurance rate filing the amount of these assessments as provided for in Subtitle 17A of this chapter.

(9) Insurers shall pay any assessment amounts authorized in KRS 304.17B-001 to

304.17B-031 within thirty (30) days of receiving notice from the ***department*** ~~[office]~~ of the assessment amount.

(10) Any surpluses remaining in the Kentucky Access fund after completion of the assessment process for a calendar year shall be maintained for use in the assessment process for future calendar years and such funds shall not lapse. The general fund appropriations to the Kentucky Access fund shall not lapse.

(11) Assessments on health benefit plan premiums that are required under KRS 304.17B-001 to 304.17B-031 shall not be applied to premiums received by an insurer for state employees, Medicaid recipients, Medicare beneficiaries, and CHAMPUS insureds.

(12) The ***department*** ~~[office]~~ shall direct that receipts of Kentucky Access be held at interest, and may be used to offset future losses or to reduce plan premiums in accordance with the terms of KRS 304.17B-001 to 304.17B-031. As used in this subsection, "future losses" may include reserves for incurred but not reported claims.

(13) The ***department*** ~~[office]~~ shall conduct examinations of insurers and stop-loss carriers reasonably necessary to determine if the information provided by the insurers or stop-loss carriers is accurate.

(14) The insurer, as a condition of conducting health insurance business in Kentucky, shall pay the assessments specified in KRS 304.17B-001 to 304.17B-031.

(15) The stop-loss carrier, as a condition of doing health insurance business in Kentucky, shall pay the assessments specified in KRS 304.17B-001 to 304.17B-031.

➔Section 1284. KRS 304.17B-023 is amended to read as follows:

(1) After the end of each calendar year, a GAP participating insurer shall report the following information for the previous calendar year:

(a) The total earned premium in the individual, small group, large group, and association markets;

(b) The number of GAP policies in force as of December 31;

(c) The amount of the insurer's GAP premiums received during the calendar year covered by the report;

(d) The amount of the insurer's GAP claims paid during the calendar year covered by the report;

(e) The amount of the insurer's GAP losses; and

(f) Other information as the ***department*** ~~[office]~~ may require to be reported.

(2) After the end of each calendar year, and based upon the reports filed under subsection (1) of this section, the ***department*** ~~[office]~~ shall calculate and provide to each insurer who filed a report the following information relating to the calendar year:

(a) The amount of each reporting insurer's market share;

(b) The total amount of GAP premiums for all reporting insurers;

(c) The total amount of GAP claims paid by all reporting insurers;

(d) The amount of total actual GAP losses;

(e) The amount of the insurer's assessment or refund; and

(f) Other information as the ***department*** ~~[office]~~ may elect to calculate and report.

The ***department*** ~~[office]~~ shall complete its calculation and provide each insurer the results of its calculation within sixty (60) days after receiving all required information.

(3) The ***department*** ~~[office]~~ shall pay GAP losses to GAP participating insurers in accordance with this section and KRS 304.17B-021(5).

(4) The ***department*** ~~[office]~~ shall conduct examinations of insurers participating in Kentucky Access as are reasonably necessary to determine if the information provided by the insurers is accurate.

➔Section 1285. KRS 304.17B-027 is amended to read as follows:

Kentucky Access and the ***department*** ~~[office]~~ shall be exempt from all taxes levied by the

state or any of its subdivisions.

➔Section 1286. KRS 304.17B-029 is amended to read as follows:

(1) Sixty (60) days prior to the regular session of the General Assembly in the year 2002, and sixty (60) days prior to each subsequent regular session of the General Assembly thereafter, the ***department*** ~~[office]~~ shall submit a written report to the Legislative Research Commission and provide a detailed briefing. The report shall contain an evaluation of Kentucky Access, an evaluation of issues concerning high-risk individuals, and other information as the ***department*** ~~[office]~~ deems necessary.

(2) Beginning no later than June 30, 2001, and annually thereafter, the Auditor of Public Accounts shall audit Kentucky Access and within sixty (60) days of completion of the audit shall submit a copy of the audit to the Legislative Research Commission and the ***Department*** ~~[Office]~~ of Insurance.

➔Section 1287. KRS 304.17B-031 is amended to read as follows:

(1) The ***department*** ~~[office]~~ shall promulgate administrative regulations necessary to carry out the provisions of KRS 304.17B-001 to 304.17B-031.

(2) Kentucky Access shall be subject to the provisions of this subtitle, and to the following provisions of this chapter, to the extent applicable and not in conflict with the expressed provisions of this subtitle:

(a) Subtitle 1;

(b) Subtitle 2;

(c) Subtitle 3;

(d) Subtitle 5;

(e) Subtitle 8;

(f) Subtitle 9;

(g) Subtitle 12;

(h) Subtitle 14;

(i) Subtitle 17;

(j) Subtitle 17A;

(k) Subtitle 25;

(l) Subtitle 38; and

(m) Subtitle 47.

➔Section 1288. KRS 304.17B-033 is amended to read as follows:

(1) No less than annually, the Health Insurance Advisory Council shall review the list of high-cost conditions established under KRS 304.17B-001(14) and recommend changes to the ***commissioner***~~[executive director]~~. The ***commissioner***~~[executive director]~~ may accept or reject any or all of the recommendations and may make whatever changes by administrative regulation the ***commissioner***~~[executive director]~~ deems appropriate. The council, in making recommendations, and the ***commissioner***~~[executive director]~~, in making changes, shall consider, among other things, actual claims and losses on each diagnosis and advances in treatment of high-cost conditions.

(2) The ***commissioner***~~[executive director]~~ may by administrative regulation add to or delete from the list of high-cost conditions for Kentucky Access.

➔Section 1289. KRS 304.17C-010 is amended to read as follows:

As used in this subtitle, unless the context requires otherwise:

(1) "At the time of enrollment" means the same as defined in KRS 304.17A-005(2);

(2) "Enrollee" means an individual who is enrolled in a limited health service benefit plan;

(3) "Health care provider" or "provider" means the same as defined in KRS 304.17A-005(23);

(4) "Insurer" means any insurance company, health maintenance organization, self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA, provider-sponsored integrated health delivery network, self-insured employer-organized association, nonprofit hospital, medical-surgical, dental, health

service corporation, or limited health service organization authorized to transact health insurance business in Kentucky who offers a limited health service benefit plan; and

(5) "Limited health service benefit plan" means any policy or certificate that provides services for dental, vision, mental health, substance abuse, chiropractic, pharmaceutical, podiatric, or other such services as may be determined by the ***commissioner***~~[executive director]~~ to be offered under a limited health service benefit plan. A limited health service benefit plan shall not include hospital, medical, surgical, or emergency services except as these services are provided incidental to the plan.

➔Section 1290. KRS 304.17C-030 is amended to read as follows:

(1) An insurer shall disclose in writing to a covered person and an insured or enrollee, in a manner consistent with the provisions of KRS 304.14-420 to 304.14-450, the terms and conditions of its limited health service benefit plan and shall promptly provide the covered person and enrollee with written notification of any change in the terms and conditions prior to the effective date of the change. The insurer shall provide the required information at the time of enrollment and upon request thereafter.

(2) The information required to be disclosed under this section shall include a description of:

(a) Covered services and benefits to which the enrollee or other covered person is entitled;

(b) Restrictions or limitations on covered services and benefits;

(c) Financial responsibility of the covered person, including copayments and deductibles;

(d) Prior authorization and any other review requirements with respect to accessing covered services;

(e) Where and in what manner covered services may be obtained;

(f) Changes in covered services or benefits, including any addition, reduction, or elimination of specific services or benefits;

(g) The covered person's right to the following:

1. A utilization review and the procedure for initiating a utilization review, if an insurer elects to provide utilization review; and

2. An internal appeal of a utilization review decision made by or on behalf of the insurer with respect to the denial, reduction, or termination of a limited health service benefit plan or the denial of payment for a health care service, and the procedure to initiate an internal appeal;

(h) Measures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider;

(i) Other information as the ***commissioner***~~[executive director]~~ shall require by administrative regulation;

(j) A summary of the drug formulary, including but not limited to a listing of the most commonly used drugs, drugs requiring prior authorization, any restrictions, limitations, and procedures for authorization to obtain drugs not on the formulary, and, upon request of an insured or enrollee, a complete drug formulary; and

(k) A statement informing the insured or enrollee that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer.

(3) The insurer shall file the information required under this section with the ***department***~~[office]~~.

➔Section 1291. KRS 304.17C-060 is amended to read as follows:

(1) An insurer shall file with the ***commissioner***~~[executive director]~~ sample copies of any agreements it enters into with providers for the provision of health care

services. The ***commissioner***~~[executive director]~~ shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements shall include the following:

(a) A hold harmless clause that states that the provider may not, under any circumstance, including:

1. Nonpayment of moneys due to providers by the insurer;

2. Insolvency of the insurer; or

3. Breach of the agreement,

bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for noncovered services;

(b) A survivorship clause that states the hold harmless clause and continuity of care clause shall survive the termination of the agreement between the provider and the insurer; and

(c) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide health care services to the subscriber, dependent of the subscriber, or enrollee of a limited health service benefit plan, the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the ***commissioner***~~[executive director]~~ in accordance with this subsection.

(2) An insurer that enters into any risk-sharing arrangement or subcontract agreement shall file a copy of the arrangement with the ***commissioner***~~[executive director]~~. The insurer shall also file the following information regarding the risk-sharing arrangement:

(a) The number of enrollees affected by the risk-sharing arrangement;

(b) The health care services to be provided to an enrollee under the risk-sharing arrangement;

(c) The nature of the financial risk to be shared between the insurer and entity or provider, including but not limited to the method of compensation;

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with the requirements of this subtitle in exercising any delegated administrative functions; and

(e) The insurer's oversight and compliance plan regarding the standards and method of review.

(3) Nothing in this section shall be construed as requiring an insurer to submit the actual financial information agreed to between the insurer and the entity or provider. The ***commissioner***~~[executive director]~~ shall have access to a specific risk-sharing arrangement with an entity or provider upon request to the insurer. Financial information obtained by the ***department***~~[office]~~ shall be considered to be a trade secret and shall not be subject ***to***~~[tot]~~ KRS 61.872 to 61.884.

➔Section 1292. KRS 304.18-020 is amended to read as follows:

(1) "Group health insurance" is hereby declared to be that form of health insurance covering groups of persons as defined in this section, with or without one (1) or more members of their families or one (1) or more of their dependents, or covering one (1) or more members of the families or one (1) or more dependents of such groups of persons, and issued upon the following basis:

(a) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer (except as to policies insuring only against aviation or transportation hazards). The term

"employees" as used in this paragraph shall be deemed to include the officers, directors, managers and employees of the employer, the individual proprietor or partner if the employer is an individual proprietor or partnership, the officers, directors, managers and employees of subsidiary or affiliated corporations, the individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract or otherwise. The term "employees" as used in this paragraph may include retired employees. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officers. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(b) Under a policy issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. The term "employees" as used in this paragraph may include directors of corporate members and retired employees.

(c) Under a policy issued to the trustees of a fund established by two (2) or more employers in the same or related industry or by one (1) or more labor unions or by one (1) or more employers and one (1) or more labor unions or by an association as defined in paragraph (b), which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or of such association, or employees of members of such association, for the benefit of persons other than the employers or the unions or such association.

The term "employees" as used in this paragraph may include the officers, directors, managers, and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term "employees" as used in this paragraph may include retired employees. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(d) Under a policy issued to a creditor insuring a group of debtors, as defined in KRS 304.16-040, and under the same conditions and limitations as specified in such section, but the amount in indemnity payable with respect to any person insured thereunder shall not at any time exceed the aggregate of the periodic scheduled unpaid installments.

(e) Under a policy issued to any other person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under such group life policy.

(f) Under a policy issued to cover any other substantially similar group which, in the discretion of the ***commissioner***~~[executive director]~~, may be subject to the issuance of a group health policy or contract.

(2) Any group health policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group.

➔Section 1293. KRS 304.18-060 is amended to read as follows:

"Blanket health insurance" is that form of health insurance covering groups of persons as enumerated in one (1) of the following subsections under a policy or contract issued to:

(1) Any common carrier or to any operator, owner, or lessee of a means of

transportation, who or which shall be deemed the policyholder, covering a group of persons who may become passengers defined by reference to their travel status on the common carrier or the means of transportation.

(2) An employer, who shall be deemed the policyholder, covering any group of employees, dependents, or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder.

(3) A college, school or other institution of learning; a school district or districts; a school jurisdictional unit; or to the head, principal, or governing board of any such educational unit, who or which shall be deemed the policyholder, covering students, teachers, or employees.

(4) A religious, charitable, recreational, educational or civic organization or branch thereof, which shall be deemed the policyholder covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(5) A sports team, camp, or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials, or supervisors.

(6) A volunteer fire department, first aid, emergency management agency, or other such volunteer organization, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by the policyholder.

(7) A newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

(8) An association, including a labor union, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by the

policyholder.

(9) Any other person or group covering any other risk or class of risks which, in the discretion of the ***commissioner***~~[executive director]~~, may be properly eligible for blanket health insurance. The discretion of the ***commissioner***~~[executive director]~~ may be exercised on an individual risk basis or class of risks, or both.

➔Section 1294. KRS 304.18-070 is amended to read as follows:

Any insurer authorized to write health insurance in this state shall have the power to issue blanket health insurance. No such blanket policy, except as provided in subsection (4) of KRS 304.14-120, may be issued or delivered in this state unless a copy of the form thereof has been filed in accordance with KRS 304.14-120. Every such blanket policy shall contain provisions which in the opinion of the ***commissioner***~~[executive director]~~ are not less favorable to the policyholder and the individual insured than the following:

(1) A provision that the policy, including indorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in the absence of fraud be deemed a representation and not a warranty, and that no such statements shall be used in defense to a claim under the policy, unless contained in a written application. Such person, his ***or her*** beneficiary or assignee shall have the right to make a written request to the insurer for a copy of such application, and the insurer shall within fifteen (15) days after the receipt of such request at its principal office or any branch office of the insurer, deliver or mail to the person making such request a copy of such application. If such copy is not so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.

(2) A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred. Failure

to give notice within such time shall not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(3) A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after giving such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(4) A provision that in the case of a claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of a claim for any other loss, written proof of such loss must be furnished to the insurer within ninety (90) days after the date of such loss. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it is shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(6) A provision that the insurer at its own expense shall have the right and opportunity

to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

➔Section 1295. KRS 304.18-085 is amended to read as follows:

The ***commissioner***~~[executive director]~~ shall prescribe guidelines for coordination of benefits by group health insurance policies. All group health insurance policies delivered, issued for delivery, or renewed in Kentucky after July 15, 1986, shall comply with the guidelines prescribed by the ***commissioner***~~[executive director]~~.

➔Section 1296. KRS 304.18-110 is amended to read as follows:

(1) As used in this section:

(a) "Group policy" means group health insurance policies as defined in KRS 304.18-020 and blanket health insurance policies which the ***commissioner***~~[executive director]~~, in his ***or her*** discretion, designates as subject to this section, which:

1. Affect the rights of a Kentucky insured and bear a reasonable relation to Kentucky, regardless of whether delivered or issued for delivery in Kentucky;
2. Provide hospital or surgical expenses benefits, other than for a specific disease or accidental injury only; and
3. Are delivered, issued for delivery, or renewed after July 15, 2002;

(b) "Medicare" means Title XVIII of the United States Social Security Act as amended or superseded.

(2) Persons insured under group policies have the right upon termination of group membership to continue coverage for themselves and their dependents upon meeting the following conditions:

(a) The group member has been covered by the group policy or any group policy it replaced for at least three (3) months; and

(b) Notice is given to the insurer and payment of the group rate is made to the insurer, by the group member, within thirty-one (31) days after notice pursuant to subsection (7) of this section.

(3) Continued group health insurance coverage shall terminate on the earlier of:

(a) The date eighteen (18) months after the date on which the group coverage would otherwise have terminated because of termination of group membership;

(b) If the group member fails to make timely payment of premium to the insurance company, the end of the period for which premium payment was made; or

(c) The date the group policy is terminated and is not replaced by another group policy within thirty-one (31) days.

(4) If a group policy is replaced, by a succeeding insurer, persons under the continued group health insurance shall remain covered under the prior insurer's policy until it terminates in accordance with subsection (3) of this section.

(5) The right to continue group health insurance coverage shall also be available:

(a) To the surviving spouse, at the death of the group member, with respect to the spouse and such children whose coverage under the group policy would terminate or terminates by reason of the death of the group member;

(b) To a child solely with respect to himself ***or herself*** upon termination of membership in the group or his ***or her*** coverage by reason of operation of the limiting age of coverage under the group policy while covered as a dependent

thereunder; or

(c) To a former spouse for himself ***or herself*** and such children of whom he ***or she*** is awarded custody when coverage under the group policy would terminate or terminates by reason of termination of dependency as defined in the group policy and resulting from an order dissolving the marriage entered by a court of competent jurisdiction.

(6) Continuation of group health insurance coverage need not be granted in the following situations:

(a) On the effective date of coverage, the applicant is or could be covered by Medicare;

(b) On the effective date of coverage, the applicant is or could be covered by another group coverage (insured or uninsured).

(7) Notice of the right to continue group health insurance coverage shall be given as follows:

(a) For group policies delivered, issued for delivery, or renewed after July 15, 2002, the insurer shall give written notice of the right to continue group health insurance coverage to any group member entitled to continue coverage under this section upon notice from the group policyholder that the group member has terminated membership in the group. The thirty-one (31) day period of subsection (2)(b) of this section shall not begin to run until the notice required by this paragraph is mailed or delivered to the last known address of the group member;

(b) If a group member becomes entitled to obtain continued health insurance coverage, pursuant to this section, and the insurer fails to give the group member written notice of the right, pursuant to this subsection, the insurer shall give written notice to the former group member as soon as practicable after being notified of the insurer's failure to give written notice of

continuation rights to the group member and such group member shall have an additional period within which to exercise continuation or conversion rights. The additional period shall expire sixty (60) days after written notice is received from the insurer. Written notice delivered or mailed to the last known address of the group member shall constitute the giving of notice for the purpose of this paragraph. If a group member makes application and pays the premium for continued health insurance coverage within the additional period allowed by this paragraph, the effective date of continued health insurance coverage shall be the date of termination from the group. However, nothing in this subsection shall require an insurer to give notice or provide continuation coverage to a former group member ninety (90) days after termination of the former group member's group coverage.

➔Section 1297. KRS 304.18-120 is amended to read as follows:

(1) A converted policy issued pursuant to the conversion privilege contained in a group policy providing hospital or surgical expense insurance shall not impose a lifetime maximum benefit of less than five hundred thousand dollars ($500,000).

(2) The ***commissioner***~~[executive director]~~ by administrative regulation shall establish minimum benefits for a converted policy issued pursuant to the conversion privilege contained in a group health policy.

➔Section 1298. KRS 304.18-124 is amended to read as follows:

As used in KRS 304.18-124 to 304.18-127, "group policy" means group health insurance policies as defined in KRS 304.18-020 and blanket health insurance policies which the ***commissioner***~~[executive director]~~, in his ***or her*** discretion, designates as subject to KRS 304.18-124 to 304.18-127, which:

(1) Affect the rights of a Kentucky insured and bear a reasonable relation to Kentucky, regardless of whether delivered or issued for delivery in Kentucky;

(2) Provide hospital or surgical expenses benefits or indemnities, other than for a specific disease or accidental injury only, or benefits for loss of time from employment; and

(3) Are delivered, issued for delivery, or renewed after July 13, 1990.

➔Section 1299. KRS 304.18-130 is amended to read as follows:

(1) Except as otherwise expressly provided herein, no contract providing major medical or outpatient care benefits, issued pursuant to Subtitles 18, 32, and 38 of KRS Chapter 304, shall be sold or offered for sale in the Commonwealth of Kentucky unless such contract offers the master policyholder the option to purchase in new contracts the minimum benefits for treatment of alcoholism as specified in KRS 304.18-140.

(2) Coverage for treatment shall be divided into three (3) distinct phases:

(a) Emergency detoxification treatment;

(b) Residential treatment; and

(c) Outpatient treatment.

Such contracts shall contain a stipulation that no payment shall be made by the carrier to the provider except upon completion of the phase of program of treatment by the patient, under the guidance and direction of a physician licensed to practice in the Commonwealth or a professional, designated by such physician, who is a recognized staff member of a treatment facility licensed by the ***department*** ~~[office]~~ or accredited by the Joint Commission on the Accreditation of Hospitals.

(3) Disability and accident income benefits and basic health care contracts that do not provide major medical or outpatient care are excluded from KRS 304.18-130 to 304.18-180.

➔Section 1300. KRS 304.18-140 is amended to read as follows:

Group contracts providing major medical or outpatient care benefits issued pursuant to KRS 304.18-130 for treatment of alcoholism shall require:

(1) That the patient be under the supervision of a physician licensed to practice in the Commonwealth or a professional designated by such physician, and who is a recognized staff member of a treatment facility licensed by the ***department***~~[office]~~ or accredited by the Joint Commission on the Accreditation of Hospitals;

(2) That the patient receive appropriate emergency detoxification treatment, residential treatment and outpatient treatment at facilities licensed by the ***department***~~[office]~~ or accredited by the Joint Commission on the Accreditation of Hospitals, for alcoholism treatment; and

(3) That the following minimum benefits per patient be provided:

(a) Emergency detoxification - 3 days, $40 per day

(b) Residential treatment - 10 days, $50 per day

(c) Outpatient treatment - 10 visits, $10 per visit.

➔Section 1301. KRS 304.18-180 is amended to read as follows:

The ***commissioner***~~[executive director]~~ of insurance shall administer the provisions of KRS 304.18-130 to 304.18-170 and may adopt rules and regulations to implement the provisions of KRS 304.18-130 to 304.18-170.

➔Section 1302. KRS 304.19-080 is amended to read as follows:

(1) All such policies, certificates of insurance, notices of proposed insurance, applications for insurance, indorsements and riders delivered or issued for delivery in this state and the schedule of premium rates pertaining thereto shall be filed with the ***commissioner***~~[executive director]~~.

(2) All life insurance and all health insurance in connection with loans or other credit transactions shall be subject to the provisions of this subtitle, except health insurance in connection with a loan or other credit transaction of more than five (5) years' duration or life insurance in connection with a loan or other credit transaction of more than ten (10) years' duration; nor shall insurance be subject to provisions of this subtitle where the issuance of such insurance is an isolated transaction on the

part of the insurer not relating to an agreement or a plan for insuring debtors of the creditor; nor shall insurance issued for an amount in excess of forty thousand dollars ($40,000) be subject to this subtitle.

(3) (a) Credit life insurance. The premium rates set forth hereunder, or actuarially equivalent, shall not exceed:

1. For decreasing term credit life insurance, a single premium of sixty cents ($0.60) per annum per one hundred dollars ($100) of scheduled indebtedness, or sixty-five cents ($0.65) per annum per one hundred dollars ($100) of scheduled indebtedness if dismemberment benefits are included in the policy.

2. Single premium rates for indebtedness repayable in monthly installments other than twelve (12) in number shall not exceed one-twelfth (1/12) of the above premium rate multiplied by the number of full months in the scheduled period.

3. A premium payable monthly at the rate of ninety-two cents ($0.92) per one thousand dollars ($1,000) of outstanding unpaid insured indebtedness or one dollar ($1) per one thousand dollars ($1,000) of outstanding unpaid insured indebtedness if dismemberment benefits are included in the policy, will be deemed the actuarial equivalent of the foregoing rates.

4. For level term credit life insurance, a single premium of one dollar and twenty cents ($1.20) per annum per one hundred dollars ($100) of indebtedness or one dollar and thirty cents ($1.30) per one hundred dollars ($100) of indebtedness if dismemberment benefits are included in the policy.

(b) 1. The standards set forth above are applicable to a plan of death benefits with or without requirements for evidence of insurability which contain

no exclusions except for suicide; other exclusions must receive the approval of the ***commissioner.*** ~~[executive director, and]~~

2. Coverage shall be offered to all debtors regardless of age; or to all debtors not older than the applicable age limit which shall be not less than sixty-five (65) at the inception of the indebtedness or sixty-six (66) at the scheduled maturity date of the transaction, provided that each company's right to underwrite risks on an individual basis shall not be restricted by this subparagraph. Appropriate adjustments may be made with the approval of the ***commissioner*** ~~[executive director]~~ if premium rates are determined according to the age of the insured debtor or by age brackets.

3. Rates for use with forms which are more restrictive in any material respect shall reflect such variations in lower rates. Similarly, forms providing more extensive benefits than set forth above may carry appropriately higher charges.

4. The standards set forth above shall be applicable to contracts which may contain a provision excluding or denying a claim for death, resulting from pre-existing illness, disease or physical condition for which the debtor received medical advice, consultation or treatment during the twelve (12) month period immediately preceding the effective date of the debtor's coverage and which would ordinarily be expected to affect materially the debtor's health during the period of coverage; provided, however, that after such coverage has been in force for six (6) months (twelve (12) months for contracts of more than three (3) years), this pre-existing exclusion clause shall not operate to deny coverage for any death thereafter. The contract shall contain no other provision which excludes or restricts liability in the event of death caused in a certain

specified manner, except provisions excluding or restricting coverage in the event of intentionally self-inflicted injuries, foreign travel or residence, flight in nonscheduled aircraft, war or military service.

(4) (a) Credit health insurance. The following premium rates, or actuarially equivalent rates, shall be charged for the coverages set forth hereunder:

Single Premium Per $100 of Initial Indebtedness

	Nonretroactive Basis		Retroactive Basis	
Number of Monthly Installments	14-Day Wait	30-Day Wait	14-Day Wait	30-Day Wait
1-6 months	$ 1.51	$ .69	$2.02	$ .92
7-12 months	2.02	.91	2.69	1.22
13-19 months	2.50	1.56	3.33	2.08
20-24 months	2.93	1.84	3.91	2.45
25-30 months	3.28	2.34	4.37	3.12
31-36 months	3.85	2.77	5.14	3.70
37-48 months	4.77	3.67	6.36	4.89
49-60 months	5.68	4.58	7.58	6.11

(b) 1. The standards set forth above shall be applicable to contracts which may contain a provision excluding or denying a claim for disability, resulting from pre-existing illness, disease or physical condition for which the debtor received medical advice, consultation or treatment during the twelve (12) month period immediately preceding the effective date of the debtor's coverage and which would ordinarily be expected to affect materially the debtor's health during the period of coverage; provided,

however, that after such coverage has been in force for six (6) months (twelve (12) months for contracts of more than three (3) years), this pre-existing exclusion clause shall not operate to deny coverage for any disability commencing thereafter. The contract shall contain no other provision which excludes or restricts liability in the event of disability caused in a certain specified manner, except provisions excluding or restricting coverage in the event of pregnancy, intentionally self-inflicted injuries, foreign travel or residence, flight in nonscheduled aircraft, war or military service.

2. Coverage shall be offered to all debtors regardless of age, or to all debtors not older than the applicable age limit which shall be not less than sixty-five (65) at the inception of the indebtedness or sixty-six (66) at the scheduled maturity date of the transaction, provided that each company's right to underwrite risks on an individual basis shall not be restricted by this subparagraph. Appropriate adjustments may be made with the approval of the ***commissioner***~~[executive director]~~ if premium rates are determined according to the age of the insured debtor or by age brackets.

3. Rates for use with forms which are more restrictive in any material respect shall reflect such variations in lower rates. Similarly, forms providing more extensive benefits than set forth above may carry appropriately higher charges.

(5) Statistical reporting. Each insurer writing credit life or credit health insurance within this state shall keep and maintain statistical data of its experience on these kinds of insurance. The insurer shall, on or before May 1 of each year, file with the ***commissioner***~~[executive director]~~ its statistical experience data for the year ending December 31 immediately preceding. Such experience shall be reported on forms

conforming to those now or hereafter from time to time adopted by the National Association of Insurance Commissioners.

(6) If a group policy has been delivered in this state before June 18, 1980, or has been or is delivered in another state before or on or after June 18, 1980, the insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this state as specified in subsections (2) and (4) of KRS 304.19-070, and such forms shall be approved by the ***commissioner***~~[executive director]~~ if they conform with the requirements specified in such subsections and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates filed with the ***commissioner***~~[executive director]~~. The premium rate in effect on existing group policies may be continued until the first policy anniversary date following June 18, 1980. After June 18, 1980, no borrower shall be added to an existing group policy at rates higher than those set forth in subsections (3) and (4) of this section.

(7) The foregoing rates and procedures are deemed to be legislative prerogatives and shall not be subject to administrative or executive change or modification.

➔Section 1303. KRS 304.19-082 is amended to read as follows:

(1) Notwithstanding KRS 304.19-080, an insurer issuing credit health insurance coverage to credit union borrowers, when the coverage is not required as a condition of the loan, may use higher credit health insurance premium rates for specific credit unions if the rates for those credit unions have been filed with the ***commissioner***~~[executive director]~~, and within thirty (30) days of the filing the ***commissioner***~~[executive director]~~ has not disapproved the rate as excessive in relation to the benefits provided.

(2) In determining whether to disapprove any rate, the ***commissioner***~~[executive director]~~ shall give due consideration to the morbidity costs with respect to the